CITIZENS' COUNCIL FOR HEALTH FREEDOM
cchfreedom.org

MEDICARE HOW-TO GUIDE

Helping you make an **educated Medicare Decision** ... until there's a better option for all Americans.

OCTOBER 2024

IMPORTANT DISCLAIMER FROM CCHF

Medicare How-To Guide is for information purposes only. The Guide is not medical advice, financial advice, legal advice, or insurance advice and should not be treated as such advice.

Medicare has not reviewed nor endorsed this information. The guide is not connected with or endorsed by the United States government or the federal Medicare program. You are free to contact Medicare.gov at any time (1-800-MEDICARE) or your local State Health Insurance Program for assistance with Medicare enrollment or plan choices.

Medicare How-To Guide has also not been reviewed by or endorsed by any other coverage option discussed in this guide, such as Medigap insurance companies or health care sharing organizations. The guide is solely an educational product of CCHF.

Although we are trying to accurately inform readers, including over 300 endnotes to support the enclosed information, **Citizens' Council for Health Freedom makes no claim as to the veracity of the information within the Guide.**

Federal Medicare laws, guidance documents, rules, regulations, notices, memos, premiums, and options in your state for Medicare Advantage and Medigap change frequently.

Therefore, when you are reading our Medicare Guide, the information may be out of date. Please check official sources and connect with a licensed Medicare agent for the latest information. Finally, CCHF may periodically update this Guide. The revision date will be included on any updated publications.

IMPORTANT NOTICE: Prices and costs in this handbook are up to date as of 2024. Many of the prices and costs for 2025 have yet to be released. CCHF will continue to update this handbook with 2025 prices and costs when they become available.

Overview

Medicare How-To Guide is published by Citizens' Council for Health Freedom, a national 501(c)3 organization with a **mission to protect patient and doctor freedom**. It was released to the public on October 21, 2024, at the start of Medicare Open Enrollment for 2025.

We know that making the MEDICARE DECISION is confusing and complex. We also know it's one of the most important decisions you will make in your life because it can determine what medical care is available to you for the rest of your life.

To help you make that decision and be better informed before you talk to a Medicare broker, we've covered basic topics, shared key terms, issued warnings, displayed various appeal processes, provided official and other resources in more than 300 endnotes, and included important insights and information transcribed from videos made by independent Medicare agents.

The inclusion of transcribed comments from seasoned health insurance brokers may make this Guide helpful in ways other guides are not.

While our ***Medicare How-To Guide*** is not small, it is intended to start you on the journey to making a decision that could affect you for a long time, including when you are sick or injured and cannot advocate for yourself.

If you wish to do your own research using government sources, the following are just three of many handbooks available from the Centers for Medicare and Medicaid Services:

- **MEDICARE & YOU 2024 (CMS)** – 128 pages
- **CHOOSING A MEDIGAP POLICY 2024 (CMS)** – 52 pages
- **UNDERSTANDING MEDICARE ADVANTAGE PLANS (CMS)** – 28 pages

OUR POSITION

After significant research, including review of government documents, broker videos, and major news media sources, we believe Original Medicare provides more freedom and patient choice than Medicare Advantage.

Freedom and choice at the most affordable price are particularly important as the Medicare program runs out of money and the government and health care industry impulse to ration medical care to senior citizens at the end of their lives increases.

WE NEED A BETTER OPTION

CCHF is working to give all Americans the right to voluntarily opt out of Medicare and purchase **real health insurance** — the affordable major medical indemnity insurance that pays the patient directly for catastrophic and insurable events and does not interfere in private medical treatment decisions.

This is how it used to work, before health plans became the law of the land, merging delivery and financing decisions, often in conflict of interest with patients.

Today, access to real health insurance is prohibited by the Affordable Care Act[1] and Americans do not have a right to opt out of Medicare unless they are willing to give up their Social Security benefits.

Because we believe the mission of medicine has been taken over by the business of health care, CCHF is also working to build a **New Framework for Health Freedom**, a cash-based parallel system of independent clinics and hospitals, where doctors and patients work together in the patient's best interest; an affordable, confidential, patient-centered system of care and coverage, with full price transparency. As a first step, we launched a nationwide directory of cash-based practices at **JointheWedge.com**. It is free for patients and free for doctors.

TODAY, ACCESS TO REAL HEALTH INSURANCE IS **PROHIBITED** BY THE AFFORDABLE CARE ACT

MAKE YOUR OWN DECISION

We realize readers may not agree with our position on the preferred Medicare enrollment choice and we urge you to make your own decision.

Only you know what is best for you. You must weigh cost versus access.

Therefore, each person reading this guide is responsible for verifying all information within the guide and should consult with qualified, licensed medical, legal, financial, and insurance experts before making any Medicare decisions.

CCHF provides this ***Medicare How-To Guide*** as a resource for Americans at or nearing Medicare age. The Guide has information on each of the "Parts" of Medicare, current and projected costs, eligibility criteria, enrollment dates, Medigap plans, and much more.

You will also find **"10 Medicare Traps"** to avoid, information on Health Care Sharing, Enrollment Periods, Penalty Charts, Key Terms, a Checklist, and Questions for you to use in discussion with licensed (preferably independent) Medicare agents and retirement planners.

IMPORTANT: Do not miss the extensive list of **definitions** — you may not find a more complete one anywhere else, not even in publicly-available Medicare handbooks and websites — and be sure to use the endnotes to investigate for yourself the information found within this ***Medicare How-To Guide.***

SEEK PROFESSIONAL ADVICE

As stated above and repeated here: "Federal Medicare laws, guidance documents, rules, regulations, notices, memos, premiums, and available options in your state for Medicare Advantage and Medigap change frequently."

As time passes and laws and regulations change, this Guide may not be the most up-to-date source of information, but we hope it will be a good starting place to begin your MEDICARE DECISION journey.

NOTE: Citizens' Council for Health Freedom cannot tell you what Medicare options are best for you. Please be advised: if you contact our office seeking advice about YOUR MEDICARE DECISION, we cannot provide further information to answer questions related to your personal situation.

We hope the CCHF *Medicare How-To Guide* will prove to be a valuable resource as you seek to make the most educated decision possible for your medical and financial health.

PLEASE CONTACT A REGISTERED INSURANCE AGENT WITH KNOWLEDGE OF THE CURRENT MEDICARE OPTIONS AVAILABLE TO YOU IN YOUR GEOGRAPHIC AREA.

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Acronyms

AARP	Formerly, American Association of Retired Persons
ACA	Affordable Care Act, aka "Obamacare"
ACO	Accountable Care Organization
CBO	Congressional Budget Office
CCHF	Citizens' Council for Health Freedom
CDC	Centers for Disease Control and Prevention
CHAMP VA	Civilian Health and Medical Program of the Dept. of Veterans Affairs
CMS	Centers for Medicare & Medicaid Services
CPI-U	Consumer Price Index for all Urban Consumers
FDA	U.S. Food & Drug Administration
GHD	Plan G High Deductible (Medigap)
HCSM	Health Care Sharing Ministry
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
IEP	Initial Enrollment Period
IRMAA	Income Related Monthly Adjusted Amount (Part B)
KFF	Kaiser Family Foundation – resource for news and policy
MA	Medicare Advantage
MD	Medical Doctor
MPH	Master of Public Health
MOOP	Maximum Out-of-Pocket
MSN	Medicare Summary Notice
OIG	Office of Inspector General
Part A	Medicare hospitalization coverage
Part B	Medicare medical coverage
Part C	Medicare health plan coverage
Part D	Medicare prescription coverage
SNF	Skilled Nursing Facility
SSA	U.S. Social Security Administration
SSN	Social Security Number

Introduction

Due to political decisions made in 1965, age 65 marks a major turning point in life. A major challenge awaits. By law, most Americans have just seven months to make the **MEDICARE DECISION.** If you or your spouse are still working or have other retirement benefits, you may be able to wait.[2]

Choosing wisely is essential. The biggest choice you must make is between Original Medicare and Medicare Advantage. You could be stuck with your decision for the rest of your life. Therefore, becoming as informed as possible about your options and possible consequences is key to making the best decision.

Connect with independent insurance agents, financial advisors, and others far enough in advance since this decision could **impact you for decades to come**.

As you open this guide, you may not yet know enough about Medicare's intricacies to ask the right questions before you make your MEDICARE DECISION.

This CCHF guide is meant to help you know more than most people know when they enter a Medicare agent's office. We hope it will help you ask the questions you need to ask. Do not miss the following sections:

12 KEY POINTS

12 QUESTIONS TO ASK MEDICARE AGENTS

10 MEDICARE TRAPS

MY MEDICARE CHECKLIST

In the end, your MEDICARE DECISION is a personal financial decision based on all the information you can learn beforehand. Do your research early before you reach age 65 and face hard and fast-approaching Medicare deadlines and the threat of lifelong penalties for delayed decisions.

We hope this guide gives you more information you and your family can use on your journey to an educated Medicare decision.

Your generous charitable (501(c)3) donation to CCHF to support this critical work to inform the American public would be greatly appreciated. Donate by going to CCHFREEDOM.ORG.

12 Key Points

Some readers may want quick advice. This section is for you. However, because Medicare is a personal and financial decision each person must make, this is a general summary of what to do and what to know before you make it. Ultimately, the decision is yours. Because it may impact the rest of your life, we cannot make it for you. We encourage you to search out additional resources and take time to do your own research before you make your MEDICARE DECISION.

1. DO YOUR RESEARCH EARLY. Although employees in companies with at least 20 workers don't have to enroll in Medicare at age 65, most Americans have just seven months to decide:

- Whether to enroll in Medicare at all or just Medicare Part A (If you do not enroll in Part A, your Social Security benefits will be withheld.)
- Whether to enroll in Medicare Part B
- Whether to enroll in Original Medicare or Medicare Advantage
- ALSO, if you enroll in Original Medicare, you have just six months (technically just 180 days) after you enroll in Part B to decide on Medicare Supplement Insurance, if you decide to enroll.

2. COUNT CURRENT AND FUTURE COSTS. Look into the future 20 to 40 years (centurions are the fastest growing segment of the population[3]), consider the impact of rising Medicare premiums over the rest of your life, and the possibility that you will not be as healthy then as you are today.

3. UNDERSTAND THAT ORIGINAL MEDICARE IS NOT FULL COVERAGE. Medicare does not provide full access to all services. Instead, "Medicare is a ***defined benefit program***, and only covers certain devices, supplies, drugs, and biologicals that have been determined to fall within a specific benefit category, are not excluded from Medicare coverage by law, and, in most cases, are reasonable and necessary . . . Medicare's statutorily-defined benefit categories are defined in Section 1861 of the [Social Security] Act."[4]

Thus, there are limits on services, supplies, drugs, and coverage for hospitalization, including just 60 Lifetime Reserve Days that do not replenish. Furthermore, the definition of "reasonable and necessary" may not align with your definition or your doctor's definition, and the definition could change as the financial situation of Medicare deteriorates. ***See Medicare Trap #6.*** Buying a ***Medigap insurance policy*** will help you cover the costs of hospitalization when Original Medicare no longer pays. If you have secondary coverage, review possible "coordination of benefits" with Medicare. ***See Definitions.***

4. KNOW THE DIFFERENCE BETWEEN ORIGINAL MEDICARE AND MEDICARE ADVANTAGE. Realize that Original Medicare does not require prior authorization—the health plan requirement that your doctor seek permission to provide you with care he or she believes is medically necessary—and has no restrictive networks. If your doctor rules your care "medically necessary," Medicare pays for it, minus your responsibility, which is determined by whether you have Medigap or not.

5. REVIEW THE REALITIES OF MEDICARE ADVANTAGE. Disregard the free benefits and zero-dollar premiums for coverage. Instead, consider the impact of limited networks, prior authorization requirements, denied payments for care, and difficulty of switching back to Original Medicare if your care is restricted by the plan.

6. MAKE A CAREFUL MEDIGAP DECISION IN THE 6 MONTHS AFTER YOU ENROLL IN PART B. After the 6-month window closes, unless the Medigap plan you choose shuts down at some point, future Medigap choices can be limited or completely denied through medical underwriting requirements.

7. CONSIDER A HIGH-DEDUCTIBLE MEDIGAP POLICY. This deductible plan is typically affordable, and it works very differently than most deductibles, as we describe in this guide. Premium increases tend to be less, and they happen less often. See if you have a high-deductible policy available in your state.

8. CONSIDER A HEALTH CARE SHARING MINISTRY INSTEAD OF MEDIGAP. While HCSMs are not considered insurance or "creditable coverage," the cost of coverage is often less. HCSM may also cover items not available in Original Medicare or Medicare Advantage. For example, ministries may cover the cost of going to a cash-based practice that has opted out of Medicare. Be aware that these ministries often require you to submit your own bills to the ministry for reimbursement. Consider your ability to do this as you age.

9. PAY YOUR BILLS ON TIME. Know when to look for your bills in the mail and mail a check immediately, unless you have automatic withdrawal, or your payment is being taken from your Social Security checks. Failure to make timely payments could lead to termination from Medicare, coverage gaps, lifelong penalties, and limited coverage choices when you reapply.

10. READ THE DEFINITIONS. We have included an extensive **"KEY TERMS"** list at the end of this guide, including some important notes of explanation. While there are many other terms, we believe these definitions provide significant details to understand the Medicare programs, its pitfalls, and your rights and responsibilities.

11. KEEP TRACK OF ENROLLMENT OPPORTUNITIES AND DEADLINES. There are terms and definitions, deadlines, and often annual calendar dates for enrollment in Medicare, Medigap, and Medicare Advantage. Missing the deadlines can result in delays in coverage, and lifelong penalties.

12. SEEK ADVICE FROM VARIOUS EXPERTS. Before you make your MEDICARE DECISION, consult with insurance agents (preferably independent agents), financial advisors, medical professionals, and legal experts.

Medicare Background and Troubling Statistics

Congress passed the Medicare bill[5] in 1965. It began enrolling elderly Americans in 1966, two years after the last Baby Boomers were born. Approximately 19.1 million[6] Americans suddenly became eligible for a **free health care program** for which they'd never paid. Today, **10,000 Baby Boomers** are entering Medicare *every day*,[7] and each could be enrolled for as long as 40 years—or more.

In 1966, the Part A hospital program was free to most while Part B premiums for medical care were **$3.00 per month**.[8] The prices charged for care skyrocketed and the government began to impose controls on payments to doctors. In 1971, U.S. Senator Ted Kennedy held four days of hearings on the Medicare cost crisis.[9]

TODAY, 10,000 BABY BOOMERS ARE ENTERING MEDICARE **EVERY DAY.**

Two years later, Kennedy's **HMO Act of 1973** to merge the delivery and financing of care became law and created a conflict of interest with patients. Those HMOs are now known today as "health plans." In 2023, about 51% of America's seniors were enrolled in Medicare Advantage health plans — the HMO version of Medicare. Enrollment is expected to grow from 54% in 2024 to 60 percent in 2030.[10]

MEDICARE IS IN DEEP TROUBLE:

- Medicare spending **exceeded dedicated funding sources by at least 45%** from 2009 to 2012, in 2020, and is expected to exceed them again in 2025.[11]
- In 2022, 65 million Americans were enrolled in Medicare,[12] and federal spending for Medicare ($905 billion) **exceeded tax revenue by $53.9 billion**.[13]
- Medicare is expanding. In 2033, an estimated **73 million Americans** will be enrolled in Medicare.[14]
- In 2036, depletion of all excess Medicare dollars is expected,[15] and **only 89% of medical bills** are expected to be paid.[16] Bills will be paid only as payroll taxes and other revenue come in.
- **Part B is mostly funded by taxpayers.** Only 25% of the cost of Part B comes from Part B premiums; 75% comes from the federal government's general fund, paid for by taxpayers.[17]
- In 2019, **reimbursement was $53.9 billion lower than actual costs** with Medicare paying on average 86.8% of the cost of services.[18]
- **Physicians are being squeezed.** In 1975, with just 26.6 million people in Medicare, physician charges were reduced 18.5% on average.[19] By 1980, reductions were 20%.[20]
- **Will you get a doctor?** Physician payment rates have plummeted by about 30% (adjusted for inflation) since 2001, reports the American Medical Association.[21]
- **No one paid sufficiently for the program.** Far above payroll taxes collected from individuals, lifetime health care cost for most couples who retired in 2021 range from $156,208 to $1,022,997.[22]

IF YOU REFUSE TO ENROLL IN MEDICARE, YOU WILL **NOT RECEIVE YOUR SOCIAL SECURITY BENEFITS**

Yet, most people are forced to enroll in Medicare. Today, if you refuse to enroll, you will not receive any Social Security checks. SSA linked them without a law. CCHF is working to change this. See page 63.

Being forced into Medicare means at least two things. First, no matter how high the cost of Medicare premiums, deductibles, coinsurance, and copayments, a senior citizen on limited or no income is forced to pay them. They have no other option. Second, no part of Medicare is free. That payment will come from their:

- **SOCIAL SECURITY CHECK (Part B)**
- **BANK ACCOUNT (Part D and Medigap)**
- **TAXES (federal taxes fund Part A and about 75% of the costs of Parts B and D)**

With insolvency imminent and health care rationing to senior citizens on the increase, **CCHF is working to create a voluntary "escape hatch" from Medicare,** which includes the right to opt out of Medicare and buy real health insurance at any age.

These affordable medical indemnity policies typically pay patients directly, solely for insurable events such as medical catastrophes or costly chronic conditions. Direct payment brings affordability and freedom. This is how it used to be. Patients with cash in hand for minor conditions or medical catastrophes:

- Reduces moral hazard
- Drives price transparency, and encourages pocket-level pricing for minor and routine care
- Allows patients to pay doctors and hospitals directly with no outside interference and without the regulatory burdens and extraordinary costs imposed by third-party-payer involvement.

In 2019, our organization, Citizens' Council for Health Freedom, secured Executive Order 13890 (Section 11) to let people opt out of Medicare:

> ***Sec. 11. Maximizing Freedom for Medicare Patients and Providers.***
>
> (a) Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, an propose other administrative improvements to Medicare enrollment processes for beneficiaries.
>
> (b) Within 1 year of the date of this order, the Secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.[23]

Unfortunately, Covid interrupted, and President Biden revoked the executive order in the first days after his inauguration.[24] At the legislative level, we also secured introduction of the **Retirement Freedom Act** in Congress to disconnect Social Security benefits from Medicare enrollment.[25] As the Medicare program heads to insolvency, our critical work to bring these efforts across the finish line continues.

AS MEDICARE HEADS TO INSOLVENCY, OUR CRITICAL WORK TO BRING THESE EFFORTS ACROSS THE FINISH LINE CONTINUES.

Original Medicare vs. Medicare Advantage

If you choose to enroll in Medicare, the next important decision you must make is between two Medicare options. As independent agent **Keith Armbrecht**, founder of Medicare on Video, says:

> "When you first come into Medicare, right off the bat, you have to choose – are you going to go with Medicare Advantage or are you going to stay with Original Medicare with a Medicare Supplement Plan? That's probably the biggest decision that you have."[26]

Original Medicare includes only Part A (hospitalization) and Part B (medical care). However, you can choose to participate only in Part A, which is free to most Americans, but has surprisingly limited hospitalization coverage. This could cause financial distress if your hospitalization falls outside of Medicare Part A payments.

Medicare Advantage plans include benefits from the same ***category*** of benefits offered by Part A and Part B and often include Part D (prescription drugs). ***MA plans "do not offer the same benefits as Original Medicare, just benefits from the same categories.*** For example, if your doctor recommends 20 sessions of physical therapy, with Original Medicare you get 20 sessions. With an Advantage Plan you may only get 5."[27] Same benefit category, not the same benefit. As Medicare Interactive states, ***"Each Medicare Advantage Plan must provide all Part A and Part B services covered by Original Medicare but they can do so with different rules, costs, and restrictions that can affect how and when you receive care."***

You must enroll in Part A and Part B to enroll in Medicare Advantage. Original Medicare is run by the federal government. Medicare Advantage is run by private Medicare-approved health plans, which receive payment from the federal government.[28]

ORIGINAL MEDICARE IS RUN BY THE **FEDERAL GOV'T.**

MEDICARE ADVANTAGE IS RUN BY PRIVATE **MEDICARE-APPROVED HEALTH PLANS.**

AARP describes the difference in access to care: "Think of it as choosing between ordering the prix fixe meal (Medicare Advantage) at a restaurant, where the courses are already selected for you, or going to the buffet (original Medicare), where you must decide for yourself what you want."[29]

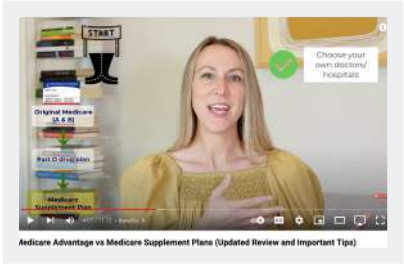
Armbrecht explains: "Keep in mind, the lower the premium with Medicare Advantage, typically the more restrictive it is. So, it'll have a small network, less hospitals, things of that nature within the Medicare Advantage plan."

The cost of using Medicare Advantage might also surprise you. "The out-of-pocket in a Medicare Advantage plan is where it can get really expensive, so you need to understand that as well," adds Arm-

brecht. "It's kind of a pay-as-you-go. You'll have co-pays and you'll have out-of-pocket expenses within a Medicare Advantage plan when you use it." In 2023, the maximum out-of-pocket was $8300.[30]

The decision is yours, however the following statements provide reasons to seriously consider avoiding Medicare Advantage and choosing Original Medicare:

"I absolutely would do whatever I could to stay on Original Medicare. It just gives much more freedom of choice. You can choose your doctor, your hospitals. The out-of-pocket is super low. It's easy to use and that's what we want when we're going into our later years when we're going to need health care more than we've ever had before."
- Keith Armbrecht, founder of Medicare on Video [31]



"[Original Medicare] means that you can maintain the freedom to visit any Medicare doctor anywhere in the country. And most any medically necessary service is going to be covered by parts A and B. Your doctor or hospital will bill Medicare as your primary insurance." **- Stephanie Abt, Abt Insurance** [32]

"This means that because you have Original Medicare, no matter which Medicare supplement plan or which insurance company you choose, you retain the right to see any doctor or go to any hospital that accepts Medicare. And your doctor's decisions and opinions guide your health care. And neither you nor your doctor ever have to ask an insurance company for permission to have a procedure."[33] **- Matthew Claassen, CEO, MedigapSeminar.org**

"I'm in traditional Medicare and I'm happy to be there. It means that I can go anywhere I want for my care. I have not delegated to unknown administrative structures decisions as to where I can go and what care I can get. For-profit Medicare Advantage is mostly accountable to its investors and shareholders, not to patients."[34] **- Donald Berwick MD, MPP** ***(former administrator of the Centers for Medicare & Medicaid Services (CMS) during the Obama administration)***

MEDICARE DECISIONS WINDOW:

CAN DOCTORS REFUSE TO TAKE ORIGINAL MEDICARE?

Doctors are not required to participate in Medicare. Despite Medicare payments being lower than payments from private insurers, most continue to participate in Original Medicare. This may change as federal officials continue to reduce Medicare payments to doctors.

Medicare recipients may occasionally face health care systems, clinics, and hospitals that claim to only take Medicare Advantage. However, under CMS rules, practitioners "are not allowed to opt out of [Original] Medicare if they are a Medicare Advantage provider or furnish services covered by traditional Medicare Part B," reports KFF.[35] We found no information on how frequently this occurs; however, the following question was posed on Quora, an online forum:

> **Q:** Why would a doctor choose to only accept Medicare Advantage patients? I just got a letter from my doctor saying I would have to choose a Medicare Advantage plan or change doctors.[36]

A patient explained in a March 2024 YouTube comment what she did in a similar situation and what happened when she was denied:

> "I was told by 2 Hospitals and a few doctor groups they only accept Medicare Advantage. After many phone calls and a long talk with UHC [United Healthcare] I called a person back who had denied me earlier and I said if you accept Medicare Advantage you have top [sic] accept original and she laughed and said your [sic] right. My head was about [to] explode but I stayed cool And now I am finally in the system." — @beoz658[37]

One possible reason for this behavior is the federal primary care bonus program. Medicare Advantage health plans pay bonuses to doctors for meeting certain performance metrics and treatment criteria.[38] For example, according to the UnitedHealthcare's **Medicare Advantage Primary Care Physician Incentive Program** Terms and Conditions, there are three types of bonuses available:

- **QUALITY CARE BONUS OPPORTUNITIES**
- **ACHIEVEMENT BONUS OPPORTUNITY**
- **IMPROVEMENT BONUSES**

For example, by completing a High-Priority Annual Care Visit (ACV), doctors could receive $200. For prescribing statins to patients with diabetes, a $20 bonus is available.[39]

DOES MEDICARE ADVANTAGE RATION CARE?

As you try to decide between the original and the health plan versions of Medicare, government reports may make the decision easier. The Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS) has issued several reports related to the rationing of medically necessary care by Medicare Advantage plans.

In 2018, the OIG reported that appeals of denied medical care or denied payment for care led to health plans overturning **75 percent** of the denials, however, only **1 percent** of denials were ever appealed.[40] Thus, denials of care may be a lucrative strategy for health plans. Medicare Advantage denials are also in the news. As Kenneth Williams, CEO of Alliance Health Care told NBC news in October 2023:

> **"They don't want to reimburse for anything — deny, deny, deny ... They are taking over Medicare and they are taking advantage of elderly patients."** [41]

Delays are also a problem in Medicare Advantage. eHealth reports, "One of the primary challenges doctors face is referral and pre-authorization requirements that may impede a patient's needed medical care. Taking the extra steps in some cases may slow down the process when a patient needs tests or treatments sooner rather than later."[42] Alternatively, Original Medicare has no referral or prior authorization requirements.

Congress has long pushed to get seniors enrolled in Medicare Advantage **(see Part D)**. This may be why the Advantage program receives more federal funding than Original Medicare. In 2024, the federal government will pay Medicare Advantage plans **$83 billion more** than is spent for Original Medicare.[43]

Part of this enormous outlay of taxpayer dollars may result from health plans **"upcoding"** the diagnoses of senior citizens to make them look "sicker" – a subject now under federal scrutiny. The fixed per month per member (PMPM) federal payments to Advantage plans, federal quality bonus payments (expected to be at least $11.8 billion in 2024), and the statutory authority of health plans to ration care (e.g. prior authorization, limited networks) may be why Advantage plans can offer financial inducements for enrollment, such as zero-premium plans and the SilverSneakers® gym program.

At least two protective solutions exist for those who prefer Medicare Advantage. One option is continued or new membership in a health care sharing organization to cover the costs not covered by the Medicare Advantage plan, including preventive care that Medicare does not cover.[44] Another option is explained by independent broker Matthew Claassen, CEO of MedicareSeminars.org:

> "General inflation. . . along with increasing medical costs push up the price of Original Medicare and increase the deductibles and Part A coinsurance. That directly impacts Medicare Advantage plans, which respond by reducing benefits and increasing consumer's maximum out-of-pocket potential costs for medical bills. You can hedge against these increased costs and decreased benefits over your lifetime with an inexpensive **critical and chronic illness indemnity plan.**"[45]

Medicare Part A (Hospital Coverage)

Medicare Part A coverage is for and may include:[46]

- **Inpatient Care in a Hospital**
- **Skilled Nursing Facility Care**
- **Nursing Home Care**
- **Hospice Care**
- **Home Health Care**
- **Psychiatric hospital**

Specific to hospitalization, Medicare Part A covers semi-private rooms, meals, general nursing, drugs (including methadone to treat an opioid use disorder) and "other hospital services and supplies as part of your inpatient treatment." What is a "hospital"? Medicare lists the following facilities:

- **Acute care hospitals**
- **Critical access hospitals**
- **Inpatient psychiatric facilities**
- **Inpatient rehabilitation facilities**
- **Long-term care hospitals**[47]

Surprisingly, Medicare Part A covers no physician fees during a hospital stay. These costs fall under Part B coverage, reports MedicalNewsToday.[48] The Medicare.gov website agrees: "If you also have Part B, it generally covers 80 percent of the Medicare-approved amount for doctor's services you get while you're in a hospital."[49]

WHEN DO I ENROLL?

The initial enrollment period (IEP) for Medicare Part A is **seven months** (the 3 months before your birth month, your birth month, and the 3 months after your birth month). There is one exception to this rule. If your birthday is the first day of a month, your entire initial enrollment period moves forward by one month. Check out the Medicare Initial Enrollment Period Calculator found at MedigapSeminars.org: https://medigapseminars.org/medigap-calculator/. [50]

If you work past age 65 with creditable employer-sponsored health insurance, use a Special Enrollment Period (SEP) and sign up within 8 months of the day you or your spouse stop working or your group health plan ends.

IMPORTANT CHANGE FOR 2025: Due to a recent federal law change, you may need to enroll in Part D even If you work past age 65 with employer-sponsored health insurance. The Inflation Reduction Act of 2022 changed the maximum out-of-pocket cap from $8,000 in 2024 to $2000 in 2025.[51]

If you are Medicare-eligible but still working in a company with 20 or more employees, and if your employer's prescription drug coverage is deemed non-creditable due to the change in the maximum out-of-pocket cap, you may be forced to purchase a standalone Part D plan or face a lifetime of financial penalties if in the future you choose to enroll in Part D. Stay tuned for developments.

DO I HAVE TO GET MEDICARE PART A?

No, but if you do not enroll in Medicare Part A, the Social Security Administration will not send you your earned Social Security Retirement Benefits. Also, if you do not qualify for "premium-free Part A," and choose to enroll outside of qualified enrollment periods, you will likely incur a 10 percent penalty for twice as many years as you were eligible but chose not to enroll. MedicareFAQ has a handy calculator to determine the cost of your premium and your penalty.[52] See the endnote.

HOW MUCH DOES IT COST?

Part A is provided at no cost to most Americans if they paid Medicare payroll taxes for at least 10 years while employed. Those who do not qualify must pay $278 - $506 per month for Part A coverage.[53]

WHAT IS MY DEDUCTIBLE?

In 2024, your deductible is $1,632 for ***each*** hospitalization "benefit period" – Claassen calls this the "per event deductible."[54] The Part A deductible must be met per benefit period, not per calendar year.[55] A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a skilled nursing facility) for 60 days in a row.

One way to avoid paying the deductible is to purchase a Medigap plan. *(See page 34)*

WHAT IF I'M IN THE HOSPITAL FOR LONGER THAN ONE DAY?

For days 1-60, you pay $0.00 per day—after your $1,632 deductible. For days 61-90, you must pay $408 per day in coinsurance and for days 91-150 you must use your 60 lifetime reserve days and pay $816 per day in coinsurance. If your hospital stay extends beyond 150 days, you must pay the entire bill.

LENGTH OF STAY	WHAT PATIENT PAYS PER BENEFIT PERIOD
Days 1 - 60	$0.00 after paying your $1,632.00 deductible
Days 61 - 90	$408.00/day
Days 91 - 150	$816.00/day while using up your 60 lifetime reserve days.
Day 151+	Not Covered. Pay all costs unless have Medigap coverage.

If you have a Medigap policy, it will likely cover the cost of the deductible and the coinsurance for each benefit period. Check your policy. Medigap policies typically cover up to 365 days of inpatient hospitalization after a person has used all lifetime reserve days."[56]

WHAT IS MY NETWORK? (I.E. WHICH HOSPITALS CAN I GO TO?)

With Parts A and B of Original Medicare, there is no network. Nearly all hospitals in America accept payments from Original Medicare. However, if you select a Medicare Advantage plan for your coverage, you will probably be subject to a limited network of practitioners and hospitals.

WHAT DOES MEDICARE PART A NOT COVER?

While Part A covers hospitalizations, it does not cover private-duty nursing, a private room (unless medically necessary), a television or phone in your room (if there's a separate charge for these), or personal care items (like razors or slipper socks). Also, Medicare only pays up to 190 days of inpatient mental health care in a ***freestanding*** psychiatric hospital during your ***lifetime***.[57]

Furthermore, while Medicare Part A covers "home care," it does not cover long-term care, or non-skilled personal care. For example, help with activities of daily living such as bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom are not covered. It also does not cover 24-hour care at home, meals delivered to your home, or services such as shopping, cleaning, and laundry.[58]

ADDITIONAL THINGS TO KNOW ABOUT MEDICARE PART A:

LIFETIME RESERVE DAYS: Every person enrolled in Medicare Part A receives **60** lifetime reserve days that are only used when you exceed 90 consecutive days in a hospital during a benefit period. **These days cannot be replenished**. When Medicare recipients run out of lifetime reserve days, they are responsible for 100 percent of incurred costs, unless a Medigap policy covers those expenses. Most Medigap policies cover up to an addition 365 days after all lifetime reserve days are used.[59] Lifetime reserve days do not apply to the cost of stays at skilled nursing facilities.[60]

COMMON ITEMS AND SERVICES NOT INCLUDED IN PART A: Long-term care, most dental care, eye exams for prescription glasses, dentures, cosmetic surgery, massage therapy, routine physical exams, hearing aids and exams, and concierge care.[61] Other services not covered under Medicare can be found at CMS.gov (Medicare.gov/what-medicare-covers/what-isn't-covered-by-part-a-part-b).[62]

PHYSICIANS AND OTHER PRACTITIONERS **DO NOT** HAVE TO PARTICIPATE IN MEDICARE.

"OPTED OUT" PRACTITIONERS: Physicians and other practitioners do not have to participate in Medicare. If a physician or other clinician has "opted-out" of Medicare, no items or services from that practitioner will be covered by Medicare. The practitioner can determine their own prices, and the patient is responsible for the entire bill.

In 2023, the overall opt-out rate for physicians was 1.1 percent (11,039 physicians). However, 7.7 percent of psychiatrists, 4.2 percent of plastic and reconstructive surgery physicians, and 2.8 percent of neurologists opted out.[63]

NOTE: A patient enrolled in Medicare may pay a practitioner who has opted out of Medicare directly using cash, check, or credit card.

To find an opted-out doctor, check out the list on the CMS website, which states there are 43,000 total opted out providers as of June 2024: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits.[64]

Find doctors or facility that accepts Medicare assignment or participate in Medicare by visiting: https://www.medicare.gov/care-compare/

Medicare Part B (Medical Coverage)

Medicare Part B covers preventive services and medically necessary services or supplies needed to diagnose or treat a medical condition. This may include:[65]

- **Physician/Provider Services**
- **Ambulance Services**
- **Clinical Research**
- **Medical Equipment**
- **Some Prescription Drugs**
- **Mental Health (inpatient, outpatient, partial hospitalization, etc.)**

WHEN DO I ENROLL?

The initial enrollment period (IEP) for Medicare Part B is seven months (the 3 months before your birth month, your birth month, and the 3 months after your birth month). There is one exception to this rule. If your birthday is the first day of a month, your entire initial enrollment period moves forward by one month. Check out the **Medicare Initial Enrollment Period Calculator** found at MedigapSeminars.org: https://medigapseminars.org/medigap-calculator/.[66]

If you work past age 65 with creditable employer-sponsored health insurance, use a Special Enrollment Period (SEP) and sign up within 8 months of the day you or your spouse stop working or your group health plan ends.

DO I HAVE TO GET MEDICARE PART B?

No, but in most cases you will be penalized if you change your mind and enroll later. If you enroll in Part B outside of a qualified enrollment period, you will incur a 10 percent penalty for each 12 months you were eligible but did not enroll.[67] This is a lifelong penalty. We've created a chart on potential savings and costs over 30 years of such a decision: bit.ly/PartBpenalty

DO I NEED PART A TO GET PART B?

Yes, unless you are required to pay for Medicare Part A (hospital insurance). Per the Social Security Administration (SSA): "If you're not eligible for Part A at no cost, you can buy Part B without having to buy Part A," as long as you meet two conditions: 1) you must be age 65 or older, and 2) you must be a U.S. citizen OR a lawfully-admitted non-citizen who has lived in the U.S. for five years or longer. ("Medicare," Social Security Administration, 2024: https://www.ssa.gov/pubs/EN-05-10043.pdf)

HOW MUCH DOES IT COST?

Part B premium costs are tied to inflation and increase most years. Premiums won't be finalized until fall of 2024, but the Medicare Trustees Report *projects* a 5.6% increase: $185 per month. **Stay tuned.** In 2024, most people paid $174.70 per month, deducted automatically from their social security or billed on the 25th of each month.[68] ***(NOTE:** If premiums are not deducted automatically, look for your Part B bill to arrive in your mailboxes on the 10th day of the month.)* The $174.70 charge was an increase of $9.80 (6%) from the 2023 rate of $164.90.[69] High income individuals — beginning at $97,000 for an individual and $194,000 for a married couple — are subject to higher premium rates.[70] This added charge is called the **Income Related Monthly Adjusted Amount** (IRMAA, pronounced "ur-ma").

WHAT ARE MY DEDUCTIBLE AND COINSURANCE?

The 2025 deductible won't be finalized until fall 2024. According to the Medicare Trustee Report, it will increase to $257. Stay tuned. In 2024, individuals paid $240 deductible plus coinsurance, which is 20 percent of the Medicare-approved charge for services. In 2023, the Part B deductible was $226.[71]

WILL MY DOCTOR ACCEPT MEDICARE AS PAYMENT IN FULL?

According to the Medicare administration there are three possibilities:[72]

1. DOCTORS THAT ACCEPT FULL ASSIGNMENT – "They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share. . . They submit your claim directly to Medicare." Thus, they accept Medicare-approved charges as payment in full.

As eHealth explains: "In addition to accepting Medicare insurance, the doctor agrees to charge the Medicare-approved amount for services rendered. If you work with a participating provider, your doctor's office will handle all billing paperwork and you will generally be responsible for 20 percent of the cost of the service you receive, while Medicare pays 80 percent (once your Part B deductible is met)."[73]

The Medicare-approved rate for more than 10,000 services is listed in the **Medicare Physician Fee Schedule** (MPFS). Medicare has created the "CMS MPFS Look-Up Tool" to provide patients and practitioners with information on pricing, Medicare payment policies, and more.[74] Find the tool at:

- https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf
- https://www.cms.gov/medicare/physician-fee-schedule/search/overview

NOTE: Providers must make **"reasonable" efforts to collect** the 20% copayment from the patient.[75] Failure to make reasonable collection efforts forbids the provider from deeming the loss as **"bad debt"** and seeking federal reimbursement. If the debt remains unpaid more than 120 days after the first bill is sent to the patient, the debt may be deemed as "uncollectible."[76] The **Medicare bad debt program** "reimburses providers 65 percent of their allowable Medicare bad debt amounts that remain unpaid."[77]

2. DOCTORS THAT DON'T ACCEPT MEDICARE AS FULL PAYMENT – These "non-participating" doctors can choose to accept the Medicare-approved amount on a case-by-case basis. You may need to pay the full amount at the time of service. They should submit a claim to Medicare, but if they don't you can use a Medicare claim form to submit your own claim. They can charge 15 percent over the Medicare-approved amount for a service. This is called a "limiting charge" or "excess charges."

3. DOCTORS THAT OPT-OUT OF MEDICARE – Opted-out physicians do not work with Medicare. Medicare will not pay for items or services you receive from doctors that opt out, except in emergencies, even if they are Medicare-covered services.

CAN I NEGOTIATE PRICES IF I'M CHARGED MORE THAN MEDICARE PAYS?

The answer may depend on the doctor, the practice, the hospital, or the supplier. To learn what Medicare pays for various medical services in your area, go to https://www.cms.gov/medicare/physician-fee-schedule/search/overview

WHAT SERVICES ARE NOT INCLUDED IN PART B COVERAGE?

Common items and services not included in Medicare Part B include: long-term care, most dental care, eye exams for prescription glasses, dentures, cosmetic surgery, massage therapy, routine physical exams, hearing aids and exams, and concierge care.[78] Other services not covered under Medicare can be found at CMS.gov.[79] In addition, if a doctor or other provider is "opted-out" of Medicare, no items or services from that provider or doctor will be covered.

MANY COMMON SERVICES, SUCH AS DENTAL CARE OR EYE EXAMS, ARE **NOT** INCLUDED IN PART B.

Medicare Part C (Medicare Advantage)

Medicare Part C coverage is more commonly known as Medicare Advantage, the version of Medicare that uses private Medicare-approved health plans. These plans typically offer a comprehensive bundle of services. They "bundle your Hospital (Part A), Medicare (Part B), and usually drug coverage (Part D) into one plan. Most Medicare Advantage Plans also offer extra benefits that [Original] Medicare doesn't cover, like vision, hearing, dental, and more."[80]

DO I HAVE TO ENROLL IN MEDICARE PART C (A.K.A. MEDICARE ADVANTAGE)?

No, you do not have to enroll in a Part C Medicare Advantage plan and unlike Part A, Part B, Medigap, and Part D, there is no penalty for enrolling later during annual, special, or open enrollment periods. Typically, individuals either choose Original Medicare with a Medigap policy **OR** a Medicare Advantage plan, which includes all or some components of Part A, Part B and Part D.

WHEN DO I ENROLL?

To enroll, you must first be enrolled in Medicare Parts A and B. The initial enrollment period (IEP) for Medicare Parts A and B is seven months (the three months before your birth month, your birth month, and the three months after your birth month).

ADVANTAGE PLANS TEND TO OFFER A **COMPREHENSIVE BUNDLE** OF SERVICES.

There is one exception to this rule. If your birthday is the first day of a month, your entire initial enrollment period moves forward by one month. Check out the **Medicare Initial Enrollment Period Calculator** found at MedigapSeminars.org: https://medigapseminars.org/medigap-calculator/.[81]

If you work past age 65 with creditable employer-sponsored health insurance, use a Special Enrollment Period (SEP) and sign up within 8 months of the day you or your spouse stop working or your group health plan ends.

HOW MUCH DO PREMIUMS COST?

Advantage premiums are determined by the carriers of the plans in your geographic area and vary based on plan benefits. In 2024, the average premium cost just $18.50 per month. **"Seventy-three percent of Medicare Advantage enrollees paid no premium in 2023**; about 7 percent paid $50 or more per month," reports the Commonwealth Fund.[82] This does not include Part B premiums, which must be paid separately.[83] If Part D is not included in the Medicare Advantage plan, that premium must also be paid separately.

WHAT IS MY MAXIMUM OUT-OF-POCKET (MOOP)?

Advantage plans are "co-pay plans," says Armbrecht. They are pay as you go plans, with copays for each service and a higher maximum out-of-pocket ($8300 in 2023).[84] The out-of-pocket limit in 2024 for Medicare Advantage plans, which only applies to Part A and B services, is **$8,850 for in-network** services and $13,300 for in-network and out-of-network services combined. Since 2011, the government has required Advantage plans to limit OOP expenses for services covered by Parts A and B.[85]

WHAT IS MY DEDUCTIBLE AND COINSURANCE?

Each carrier sets the prices for deductibles and coinsurance and may offer more expensive options that include more benefits. However, some plans may offer cheap or zero-premium plans with poorer benefits, higher deductibles, and higher coinsurance. Explore available plans with an insurance agent.

DOES MY AGENT GET A COMMISSION?

The commissions received by Medicare Advantage agents and agencies vary by state. For 2025, the commission for initial enrollment in Medicare Advantage ranges from $626 per member per year in most states to $780 per member per year in California and New Jersey. The commission for renewed enrollment ranges from $313 in most states to $390 in California and New Jersey.[86] Agents also receive payments for services other than enrollment—a subject of proposed CMS regulation and several lawsuits.

ARE CANCER CENTERS COVERED?

Sixty percent (60%) of Advantage plans "do not include access to any of the 56 NCI [National Cancer Institute]-designated Comprehensive Cancer Centers" and even if access is included, enrollees may still experience barriers, reports Cure.[87]

SHOULD I BUY A MEDICARE SUPPLEMENT IF I HAVE AN ADVANTAGE PLAN?

No, Medicare supplement plans, otherwise known as Medigap plans, are only available to seniors who enroll in Original Medicare. If you have an Advantage Plan (Part C) and your health plan denies you access to needed care *(See Medicare Trap #6)* or requires significant out-of-pocket payments, you may wish you had chosen Original Medicare with a Medigap policy instead of Medicare Advantage. Medigap covers most or all your out-of-pocket costs but, again, it is not available to Advantage enrollees.

CAN I LEAVE MEDICARE ADVANTAGE AND GO BACK TO ORIGINAL MEDICARE?

According to CMS, "If you joined a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a drug plan) within the first 3 months you have Medicare Part A & Part B."[88] In addition, you can switch back to Original Medicare during the Open Enrollment Period and the Medicare Advantage Open Enrollment Period.

However, it may not be an easy decision. Access to Medigap, the insurance policies that limit your out-of-pocket expenses in Original Medicare, may be out of reach. Per KFF, "depending on how long you have been enrolled in Medicare Advantage, Medigap insurers may not be required to sell you a policy unless you meet the medical underwriting requirements. You may want to contact a few Medigap insurers directly to see if you will be able to purchase a Medigap policy when you switch to traditional [Original] Medicare."[89]

Matthew Claassen, an independent broker, has **good news**. "According to industry surveys only 20% of the underwritten applications submitted are declined by the insurance company. Which means the overwhelming majority of applicants are approved and get their new policy."[90]

He notes that many people are afraid to be underwritten so perhaps a minority of Medicare recipients try. However, his 2023 video on the medical underwriting process is an informative overview. By the end you'll likely understand medical underwriting and have a good idea **whether you will pass or be declined**: https://www.youtube.com/watch?v=c29jkM5-6bw

DO I PAY FOR "FREE BENEFITS"?

Yes and No. Medicare Advantage plans often offer 'free' gym memberships, vision, hearing and dental services, wellness programs, and over-the-counter services. In 2024 alone, Medicare Advantage (MA) plans will receive from the federal government "$83 billion (22 percent) more than what Medicare would have paid if MA enrollees were in [traditional Medicare]."[91]

These taxpayer dollars likely pay for the array of free services (enrollment incentives) and for the hefty commissions paid to brokers who enroll seniors into Medicare Advantage. In most states, the initial Medicare Advantage commissions for 2024 increased from $601 to $611 per member per year. Enrollment renewal commissions increased from $301 to $306 per member per year.[92] Add-on payments from health plans for additional services mean **brokers can earn up to $1,300 per enrollee per year.**

WHAT ARE THE 5 TYPES OF MEDICARE ADVANTAGE PLANS?

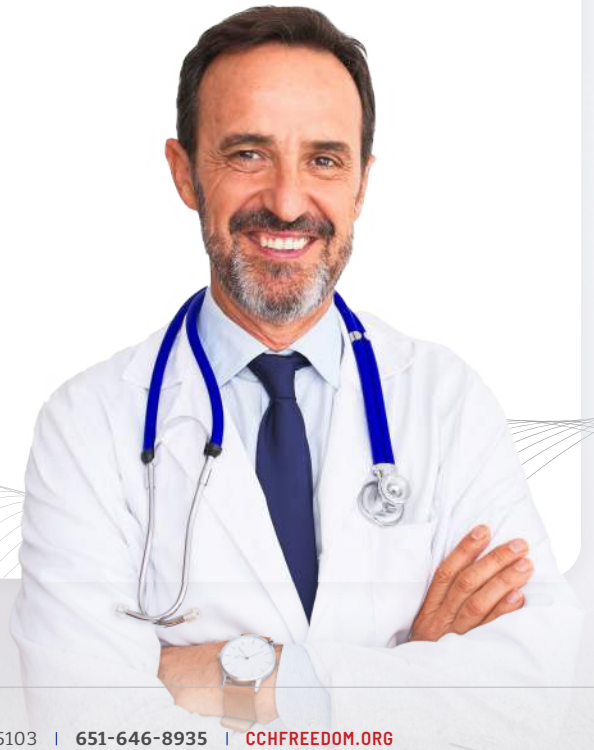
- **HMO** **(Health Maintenance Organizations)**
- **PPO** **(Preferred Providers Organizations)**
- **PFFS** **(Private Fee-for-Service Plans)**
- **SNP** **(Special Needs Plans)**
- **MSA** **(Medicare Medical Savings Accounts)**

The three most common Advantage plans chosen by seniors are HMO, PPO, and PFFS. There are benefits and drawbacks to each. For example:

- HMO plans typically have cheaper premiums and lower out-of-pocket costs but fewer doctors and health care facilities (narrow networks).
- PPO plans are usually more expensive, but you can see any doctor or hospital that accepts Medicare.
- PFFS plans have a much larger network of doctors and facilities than HMO plans but are more expensive and may be subject to balanced billing *(See pages 84 and 98).*

COMPARISON CHART:

To explore types of Medicare Advantage plans, find a comparison chart here: www.medicare.gov/media/document/12181-3-6-24.pdf?linkit_matcher=1



Medicare Part D (Prescription Drug Coverage)

Medicare Part D is coverage for outpatient prescription medications offered by government-approved private plans and other companies. **Part D premiums are heavily subsidized.** Federal General Fund dollars pay 74 percent and Medicare recipients pay just 15 percent. An additional 11 percent of revenues come from state payments for beneficiaries enrolled in both Medicare and Medicaid – the dually eligible.[93]

Part D plans do not cover all medications. They are required to cover a minimum of two prescription drugs from every category of prescription. **Be warned: your medications may not be included.** They must also cover substantially medications from six protected categories; immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.[94] Corporations that participate in Medicare Part D choose which drugs they'll cover, so make your decision carefully.

PART D PLANS DO **NOT** COVER ALL MEDICATIONS.

The plan's **drug formulary** – a list of covered medications – may change yearly or more often. To confirm that your Part D plan provides coverage for your medications, consult with your agent each year, when your medications change, or if you develop a different medical need. Medicare agents can be very helpful in this process.

NOTE: if you join a Medicare Advantage Prescription Drug plan, you will automatically be ***disenrolled*** from your stand-alone Medicare Part D prescription drug plan.[95]

WHEN DO I ENROLL?

To enroll in Part D, **you must first be enrolled in Medicare Part A**. You need a Medicare number to enroll in Part D. To avoid penalties, you must enroll in the same initial enrollment period (IEP) for Medicare Part A alone or Parts A and B. That enrollment period is seven months (the three months before your birth month, your birth month, and the three months after your birth month).

There is one exception to this rule. If your birthday is the first day of a month, your entire initial enrollment period moves forward by one month. Check out the **Medicare Initial Enrollment Period Calculator** found at MedigapSeminars.org: https://medigapseminars.org/medigap-calculator/.[96]

If you work past age 65 with creditable employer-sponsored health insurance, use a Special Enrollment Period (SEP) to sign up within 8 months of the day you or your spouse stop working or your group health plan ends.

IMPORTANT CHANGE: Due to a 2022 federal law, you may need to get Part D prescription coverage even If you work past age 65 with creditable employer-sponsored health insurance. The Inflation Reduction Act of 2022 reduced the out-of-pocket cap for prescription coverage from $8,000 in 2024 to $2,000 in 2025.[97]

If you are Medicare-eligible but still working in a company with 20 or more employees, and if your employer's prescription drug coverage is deemed *non*-creditable in 2025 (due to this change in the out-of-pocket cap), you may be **forced to purchase a standalone Part D plan** or face a lifetime of financial penalties if in the future you choose to enroll in Part D.

Because you cannot enroll in Part D without a Medicare number, you may also be forced to enroll in Medicare Part A (with or without Part B). Stay tuned as this develops. **NOTE:** If you have both Medicare and employer-sponsored insurance, the employer's insurance policy pays first.

DO I HAVE TO GET MEDICARE PART D?

No, Medicare Part D is not required.[98] However, if you do not enroll in Part D during your initial enrollment period (or when your employer's prescription coverage is deemed "not creditable,") you will likely incur a 1 percent penalty for each month you were eligible but chose not to enroll. Additionally, the same penalty will be applied if you have a period longer than 63 consecutive days without Part D coverage.[99] See our penalty chart at bit.ly/PenaltyPartD

HOW MUCH DOES IT COST?

The price for Medicare Part D varies based on geographic region and plan type. In 2024, the average price is $59 per month with a typical range of $0-195 per month.[100]

ALERT: In 2025, due to the Inflation Reduction Act of 2022, which eliminated the "donut hole" *(See page 86)*, Part D plans must limit out-of-pocket costs to no more than $2,000. To address the resulting rise in their costs to cover enrollees, drug companies have submitted their 2025 bids which include a nearly **300 percent increase** in Part D premiums. The average bid is $179.45 per month.[101] To be clear:

2024 – **national average bid $64 per month** ($768/year)

2025 – **national average bid $179 per month** ($2,148/year)

To address the significant increase in premiums, and with the critical 2024 election approaching, CMS has proposed a three-year "premium stabilization" project solely for stand-alone Part D plans. In short, CMS aims to hide the premium increase by forcing taxpayers to fund it.[102]

The project has been deemed "voluntary" for plans, but it is in fact coercive. Part D plans that refuse to participate the first year are not allowed to participate the next two years.

The government's plan, which includes price-fixing, confiscation of profits, coercion, and taxpayer-funded subsidies, is being challenged by Congress[103] as a possible **illegal transfer of costs to taxpayers** from the Part D plans and their enrollees:

- Transfer $10 billion from other parts of Medicare to lower Part D premiums
- Use the $10B to increase the taxpayer-funded subsidy from $29.58 per member per month in 2024 to $142.67 per member per month in 2025
- Reduce Part D premiums by $15/month, a taxpayer cost of $7.2 billion
- Limit yearly premium increases to $35, which could reduce premiums to $0.00[104]
- If a drug plan makes more of a profit, CMS will confiscate a portion of profits
- If a drug plan sustains a loss, CMS will subsidize a portion of the loss using confiscated funds
- End right before the 2028 election.[105]

WHAT IS MY DEDUCTIBLE?

In 2025, the maximum deductible is $590, up from $545 in 2024. It varies depending on your plan.[106]

DOES MY AGENT GET A COMMISSION?

For 2025, commissions for initial enrollment in Part D increased from $100 to $109 per member per year. Commissions for renewed enrollments increased from $50 to $55 per member per year.[107]

HISTORY OF INTEREST:

In March 2003, the prescription drug plan proposed by President George W. Bush "openly encouraged Medicare beneficiaries to leave the traditional fee-for-service program, in which 89 percent [were then] enrolled, by offering additional prescription drug coverage to those who joined private Medicare-approved health plans."[108] In July 2003, Congressional leadership rejected the Bush plan.

Congressman Billy Tauzin (R-LA), chairman of the House Energy and Commerce Committee said, **"You couldn't move my mother out of [fee-for-service] Medicare with a bulldozer.** She trusts in it, believes in it. It's served her well."[109]

The final Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which established Medicare Part D (and the Medicare Advantage program) almost didn't pass because House Republicans "insisted that private insurers and health plans should have a larger role in Medicare, to avoid any possibility that the government might set drug prices."[110]

That larger role, as reported by the HHS Office of the Inspector General, has now led to rationing of Medicare-approved, medically-necessary care by Medicare Advantage health plans.[111]

MediGap Insurance

Medicare Supplement Insurance policies, commonly called "Medigap Insurance," are intended to cover out-of-pocket costs. These plans are "guaranteed renewable for life as long as you continue to pay your premium," says broker Stephanie Abt.[112]

Supplemental policies are sold by private insurance companies and **can only be purchased by enrollees of Original Medicare.** Medigap is not available to Medicare Advantage enrollees, and, most notably, Medigap policies sold after 2005 do not cover prescription drugs.[113]

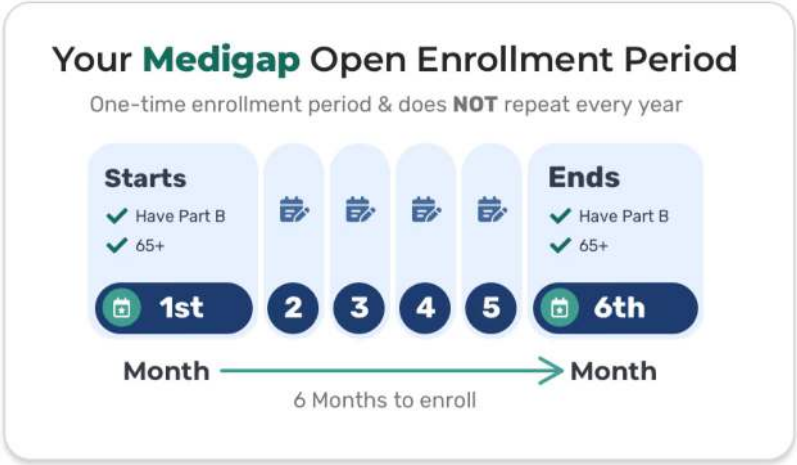
Medigap is designed to fill in the gaps not covered by payments under Medicare Part A (hospitalization), Part B (medical), and sometimes, Part D (prescription),[114] such as:

- **COPAYMENTS**
- **COINSURANCE**
- **DEDUCTIBLES**

You must enroll in both Medicare Part A and Part B to buy and keep a Medigap policy. Generally, if you pay your Medigap and Part B premiums, even if you have health problems, you will keep your supplemental insurance.[115]

WHEN DO I ENROLL?

The Medigap Open Enrollment Period is the first 6 months after enrolling in Medicare Part B.[116] However, Medicare broker Matthew Claassen says the six-month period is **"technically 180 days."** He says, "Very few insurance companies use six calendar months."[117]



Graphic from Medicare.gov

https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy#:~:text=Creditable%20coverage%20(Medigap),period%20under%20a%20Medigap%20policy

WHAT ABOUT PREEXISTING CONDITIONS?

"If you have had a least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing condition," according to Medicare.gov. If you've not had credible coverage and you've been treated or diagnosed within six months before your Medigap policy coverage starts, the Medigap insurer can wait to cover your out-of-pocket costs for up to six months.[118]

"Many types of health care coverage can count as creditable coverage for Medigap policies, but they'll only count if your break in coverage was no more than 63 days." **NOTE:** Membership in a health care sharing ministry (HCSM) is not considered creditable coverage because it is not health insurance.

After the initial 180-day open enrollment period, Medigap insurers in almost all states are allowed to reject you, impose waiting periods, or charge more based on your health. Only four states – Connecticut, Maine, Massachusetts and New York — allow their residents to switch Medigap plans regardless of pre-existing conditions.[119] **If your Medigap plan is discontinued, you will be able to choose from other available Medigap plans without medical underwriting. This is called "guaranteed issue."**

The Medigap Open Enrollment Period is a one-time open enrollment period. You will not be required to go through medical underwriting if you enroll during these first six months. No health questions will be asked, no medical records will be required for review. However, as Medicare.gov warns, "after your Medigap Open Enrollment Period ends, you may not be able to buy a policy."[120]

Medigap plans are medically underwritten if you wait to enroll after your Medigap Open Enrollment period. Underscoring this point, Medicare agent **Brian Monahan** says, "Once you go into Medicare Advantage, they [a Medigap insurer] will ask you health questions to go back into a Medigap plan 99 percent of the time." Thus, he adds, "You could be stuck in a Medicare Advantage plan for the rest of your existence unless they [Congress] change the laws."[121]

DO I HAVE TO BUY MEDIGAP COVERAGE?

No, there is no penalty for not buying a Medigap policy.

CAN I HAVE MEDIGAP IF I'M IN MEDICARE ADVANTAGE?

No. Medigap policies are only available to those enrolled in Original Medicare, not Medicare Advantage.

CAN I CHANGE MY MEDIGAP POLICY?

Probably not. According to Medicare.gov, "In most cases, you won't have a right under federal law to switch Medigap policies, unless:

- You're within your 6-month Medigap open enrollment period, or
- You're eligible under a specific situation or guaranteed issue right (when an insurance company can't deny you a Medigap policy)."

If your coverage is terminated for any reason, you are advised to "keep copies of letters, notices, emails or claim denials as proof of your coverage being terminated. You may need to include these with your Medigap application to prove you have a guaranteed right to get a new Medigap plan."[122]

HOW MUCH DOES IT COST?

Prices vary depending on the level of coverage. All Medigap plans with the same letter (A, B, C, D, F, G, K, L, M, N) have the exact same coverage — the plans are standardized nationwide — but may differ significantly in price depending on the state you live in, your ZIP code, and the company offering the Medigap plan.[123]

NOTE: Massachusetts, Minnesota, and Wisconsin laws on Medigap differ. In these states, not all Medigap plans may be available, but options may be similar to Medigap "letter options." Independent Medicare broker Matthew Claassen says, "The bottom line is there are a lot of rules and they're very difficult to find on the Internet."[124] The chart on the following page is from a 2024 Medicare publication on Medigap.[125] We would suggest you find it online and study it carefully.

CLARIFICATION: The private Medigap PLANS A, B, C, and D, which are discussed on the following pages, are not Medicare PARTS A, B, C, and D, which are the federal government coverage programs explained previously.

"THE BOTTOM LINE IS THERE ARE **A LOT OF RULES** AND THEY'RE VERY DIFFICULT TO FIND ON THE INTERNET."

This shows basic information about the different benefits Medigap plans cover

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓ ***
Blood benefit (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	X	X	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	X	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	X	X	✓	X	✓		X	X	X	X
Part B excess charge	X	X	X	X	✓	✓	X	X	X	X
Foreign travel emergency (up to plan limits)	X	X	80%	80%	80%	80%	X	X	80%	80%
							Out-of-pocket limit in 2024**			
							$7,060	$3,530		

✓ = The plan covers 100% of this benefit
X = The plan doesn't cover this benefit
% = The plan covers that percentage of this benefit, and you're responsible for the rest.

* Plans F and G offer a high-deductible plan in some states (Plan F isn't available to people new to Medicare on or after January 1, 2020.) If you get the high-deductible option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,800 in 2024 before your policy pays anything, and you must also pay a separate deductible ($250 per year) for foreign travel emergency care.

**Plans K and L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and Part B deductible ($240 in 2024). After you meet them, the plan will pay 100% of your costs for approved services for the rest of the calendar year.

*** Plan N pays 100% of the costs of Part B services, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

NOTE: Of the Medigap plans that require enrollees to pay copayments, deductibles, or coinsurance, **only the following three have maximum out-of-pocket limits**. However, the maximum out-of-pocket limits for plans K and L do not include the Part B deductible and excess charges, which those plans do not cover. ***(See above)***

MEDIGAP PLAN	MAXIMUM OUT-OF-POCKET 2024
Plan G - High Deductible	$2800*
Plan K	$7060
Plan L	$3530

* Plan GHD has an additional $250 deductible for foreign travel emergency care. Plans K and L don't cover care for emergencies in foreign countries.

WHAT IS MY DEDUCTIBLE AND COINSURANCE?

Medigap insurance typically covers all or some of the deductibles and coinsurance not covered by Medicare Part A and Part B. Each "letter plan" has different rules for deductibles and coinsurance. Read them carefully.

WHAT IS MY NETWORK?

There are no networks for Medigap insurance (it works in sync with Original Medicare, which has no networks.) You can see any doctor and use any hospital or health care facility that accepts Medicare.

CAN MY DOCTOR REFUSE MY MEDIGAP PLAN?

If your doctor accepts Medicare, they must accept your Medigap plan. As a spokesperson on The Retirement Nerds video speaking to medical billing professionals, says, "if you participate with Medicare, you do not get to pick and choose which Medicare supplement plans you work with. You must work with all Medicare supplement plans even if you do not normally work with that insurance company."[126]

DOES MEDIGAP COVER MY PART D DEDUCTIBLE?

Not usually. Some older Medigap policies do include prescription drug coverage. However, you cannot have both a Part D plan and a Medigap policy with prescription drug coverage. **WARNING:** If you ask the insurance company to remove the drug coverage from your Medigap policy, it's important to know that "you cannot get that coverage back."[127] Medigap plans that include drug coverage have not been available to purchase since 2009.[128]

WILL THERE BE EXCESS CHARGES?

When considering Medigap plan benefits, Matthew Claassen says only 2 percent of doctors have excess charges, one-half of them in mental health. Only 0.3 percent of medical bills include an excess charge. Doctors must also notify you of excess charges before treating you. "Since 2016, excess charges are illegal in these states: **Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont**."[129]

"Excess charges are almost non-existent," says **Keith Armbrecht**. Excess charges can be up to 15 percent over what Medicare pays. Therefore, if Medicare pays $50.00 for a doctor's office visit, the excess charges would be about $7.00.[130]

ARE THERE EXTRA BENEFITS?

Although Medigap plans spend 80 to 85 percent of every dollar on premiums, some offer extra benefits. You may or may not hear about these extra benefits before you choose a Medicare supplement plan because it is illegal in some states for an agent to discuss those benefits until after you've purchased the plan, says independent broker Matthew Claassen, CEO of MedicareSeminars.org.[131]

IMPORTANT: While some Medigap plans offer extra benefits, if they aren't part of your contract, they can be removed or modified at any time, leaving you with a higher-priced supplement plan and no extra benefits. Other benefits can be part of your contract and if so, cannot be altered. Extra benefits include:[132]

- SilverSneakers® / Gym memberships
- Dental, vision, and hearing discount plans, which may include a 24-hour nurse hotline (these are not insurance)
- Ability to change your supplement plan without medical underwriting, in particular, to decrease coverage (e.g. Plan N down to High Deductible plan), although the premium could be higher than if you'd picked the plan in your Initial Enrollment Period

- Ability to move up in coverage from high-deductible plan during a 30-day window at their second anniversary
- Bundled ability to change plans without underwriting for a limited amount of time and covering all your preventive care even if Medicare denies coverage
- High Deductible Plan G automatically converts to a Full Plan G after two years without increasing the premium

NOTE: One agent recommended that you focus first on the best Medigap plan for you before extra benefits even become a consideration.

WHY IS MEDIGAP IMPORTANT?

Unlike a health plan or a traditional medical insurance policy, **Medicare has no maximum out-of-pocket (MOOP)**. There is no limit to the amount you could be responsible to pay during a given year — the sky is the limit. Medigap policies are meant to protect against the possibility of ongoing or large out-of-pocket costs.[133]

Some commenters claim Medigap policies encourage "overconsumption" of medical care ($2,300 more in medical expenses per year).[134] However, **Medigap policies often pay for significant costs that Original Medicare does not cover.** For example, a 20 percent coinsurance payment is required for every Part B medical expense no matter how high that bill goes. In addition, Medicare Part A only covers a limited number of days in the hospital, per benefit period, and for a lifetime. These charges are covered by the most popular Medigap policies.

Depending on your policy, Medigap may cover the Part A hospitalization deductible ($1,632 in 2024). "Medicare supplement plans pretty much pay that in full so there's no cost when you're admitted to the hospital," says **Keith Armbrecht**, co-founder of Medicare on Video,[135] who shared on YouTube his preference for certain Medigap policies (Plans G, N, and G-High Deductible):

Best Medigap Plan 2024 - What Medicare Supplement to Choose 2024

Medicare on Video - HealthPlan65
98.8K subscribers
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Armbrecht notes that Medicare Part B is "kind of like back in the old days," where your health insurance covered 80 percent, and you paid 20 percent. The enrollee's 20 percent responsibility, as discussed above, is called 'coinsurance.' But he cautions:

> **"The problem with it in Medicare is that 20 percent does not have a stop**, so there's no out-of-pocket maximum to that 20 percent, so if it goes to a significant level, God forbid you had a million dollars under Part B, you wouldn't want to be on the hook for $200,000 out of pocket. . . This is why we want a Medicare supplement plan to go along with Parts A and B. And when we have Original Medicare A and B and a supplement plan, your out of pocket is super low and it works very, very well. And it's terrific coverage."[136]

Robert Kein, a retirement health care advisor with the Ardmore Group and policy advisor to The Heartland Institute agrees with Armbrecht's concerns about coinsurance. He says going without Medigap and without Part D coverage could be "very dangerous":

> "First, you would lose coverage for the Part A hospital deductible and the copays. Keep in mind, Medicare is not an annual deductible for Part A. It's for benefit periods of 60 days. That means one could trigger the deductible and copays multiple times in a given year. You would need a crystal ball, or a very large amount of money, to plan to invest around that."[137]

Klein warns that a $100,000 bill for doctor's fees and outpatient services (Part B) without Medigap would mean "you will likely owe $20,000." **Part B pays only 80 percent of the "reasonable charge," the reimbursement rate determined by Medicare.**[138] The Medicare recipient must pick up the remaining 20 percent (coinsurance). There is no annual cap on coinsurance. Patients are responsible for 20 percent of the reasonable charge, regardless of how many charges per year.

HOW DO SUPPLEMENT PLANS (MEDIGAP) WORK?

Supplement plans do not work the same as health plans. Specifically, you do not need to find out if your doctor "accepts" your Medigap plan. This is how independent Medicare agent **Keith Armbrecht** describes it:

> "The insurance carrier on the supplements, for the most part, doesn't matter. Because the way billing works in Medicare is, number one, if they accept Original Medicare, which the vast majority of doctors do, then they have to accept the supplement.

"There's no question whatsoever in which company, do they or don't they? That's only on the Medicare Advantage side. It's not on the Medicare supplement side. And then when you go to the doctor or the hospital or whatever's going on, the bill is submitted to Medicare. Medicare pays their part and collects from the supplement company, the Medigap company.

"So, there's no decision whatsoever on the Medigap company on whether something is approved, something is denied, is it covered. **There's none of the preauthorization that goes on in Medicare Advantage.** That's one of the fantastic reasons that I would do anything I could to stay with Original Medicare because it works like clockwork. You go to your doctor, the doctor says you need something, if it's medically necessary, that's it! You get it.

"You don't have to wait for pre-authorization and get permission and ask if it's OK and maybe try three other things before they let you try what your doctor says you need. Simply, if your doctor recommends it, you agree, and it's medically necessary, it's covered under Medicare. And if it's covered under Medicare, it's covered under your supplement.

"There's no decision from the supplement company on how things are treated or covered. If it's covered by Medicare, they have to cover it. Period. Black and white. Easy. And that's why I would stay with Original Medicare."[139]

DO MEDIGAP POLICIES HAVE TO PAY ALL CLAIMS?

"Medicare Supplement insurance carriers all must pay on any claim that has been approved by Medicare Part A or B. So, there is no one in the claims department at your Medicare Supplement insurance company deciding whether or not to approve or pay on a claim. The claims are automatically approved and must be paid in a timely matter. So claims payments are rarely an issue." – **Stephanie Abt**.[140]

HOW DO I CHOOSE A MEDIGAP POLICY?

Do your own research and find a good independent agent. Companies come and go. Frequency of price increases change. Independent broker Stephanie Abt says, "This is why no agent can really sit here and say that there is this one insurance company that is the best for Medicare supplement plans because things can and do change. **What you really want is a broker who is following the market and can alert you to these changes before they impact you.**"[141]

We listened to many excellent YouTube videos on Medigap produced over the past five years by independent insurance brokers around the country. The following **12 insights** on choosing a Medigap policy are mostly from independent insurance broker, Matthew Claassen, the CEO of MedigapSeminars,org, whose videos get rave reviews from Medicare agents and members of the public alike.

One commenter on the Medigap Seminars video channel wrote, **"I am a Medicare consultant and appreciate your explanation and honesty in explaining this topic."** We encourage you to watch videos produced by him and other agents as you do your own research. There are many agents out there; this guide quotes just a few.

1. SIX MONTHS: "**Your Medicare supplement initial enrollment period is linked to the start date of your Medicare Part B.** Once your Medicare Part B coverage starts, the clock starts ticking. You have six months; it's a six-month window where you can get any Medicare supplement plan that's available to you and no one can say "No." No one can rate you. No one can charge you more. All they can do is say "Yes" and give it to you.

"And you can change your mind and switch from one Medicare supplement plan or one Medicare insurance company to another. After that first six-months you can still change your Medicare supplement plans any day of the year. However, the insurance company has the right to look at your medical history and your prescriptions and reject your application. When an insurance company reviews your medical history, we call it 'medical underwriting.'"[142] – Claassen

If you enroll in Medigap during your six-month Medigap Open Enrollment Period and decide you don't like your Medigap policy, you have a **30-day free look back period**. If you want to change, do it then. Don't cancel your first policy before you get your second one. You will have to pay both premiums for that month you have both policies.[143]

2. REVIEW 'OUTLINE OF COVERAGE': The Outline of Coverage is a document provided by the insurance company offering Medigap coverage. "The Outline of Coverage is an official document that . . . provides a summary of your coverage. You should get an outline of coverage when you, or before you, apply for your supplement. Just ask the agent."[144] – Claassen

3. FILTER BY RISKS: "**The insurance company you choose is more important to your long-term costs than the Medicare supplement plan you choose** . . . . Finding the right insurance company is not about

finding the perfect insurance company. There is no such perfect insurance company. It's not about finding a company that will never raise prices. That doesn't exist either. It's about setting rules, setting a minimum standard by which you filter out the companies most likely to have these hidden risks. After you've filtered out the poor choices, you'll want to have a process for managing the other risks. Those are the risks that cannot be avoided."[145] – Claassen

4. KNOW YOURSELF: "**What's your personality?** Are you a peace of mind personality that prefers a Medicare supplement Plan G or are you more interested in saving money with a Medicare supplement Plan N?" asks Claassen. He says Plan N can save you $15 - $50 a month in premiums, depending on where you live. "People who choose a Medicare supplement Plan N do so because they like saving money." Plan N people, he says, value being in control of their health care choices and are budget conscious.

5. IF YOU WANT FREEDOM: "**People who choose the Medicare supplement route instead of a Medicare Advantage plan do so because** they want to keep the two most important benefits of original Medicare. What are those benefits? First, you're not limited by a network. With a Medicare supplement, you can see any doctor, go to any medical facility in the US or US territory as long as they accept Original Medicare. That is almost every doctor and medical facility in the country. Second, no insurance company has a say in your health care."[146] – Claassen

6. LOOK FOR LONGEVITY: "**There's no difference in benefits from one Medicare supplement plan offered by one insurance company and another. But there's a big difference in insurance companies** . . . Unfortunately, in Medicare, selecting a wrong insurance company can introduce another risk that you're not even aware of." Some companies are not in Medigap for the long run. They bring a new risk, says Claassen. The companies are fine, the problem is where they leave the consumer if they stop offering Medigap plans.

"When they stop selling new plans, the people that have those plans are stuck in a closed pool. It's really a **worst-case scenario for the policy holder**. You see, if an insurance company goes out of business and just stops servicing the Medicare supplement policy, Medicare gives the consumer, the policy holder, the right to get another plan. It is called "guaranteed issue." But if the company just stops selling new supplements and doesn't go belly up and is servicing existing policies, then the policy holder is stuck in a plan and can likely experience higher price increases."[147] – Claassen

7. LOOK FOR PRICE STABILITY: Look for a solid foundation in Medicare and a history of price stability. Avoid companies lowballing their prices to build market share.[148] Ask to see a history of price increases before you make a choice.

8. AVOID HIDDEN RISKS: "**The reason we get insurance, any insurance whether for a car, a home, or your health, is to take the financial risk of the event** and move it onto that of an insurance company. It's to transfer risk. Unfortunately, with Medicare, selecting the wrong insurance company can introduce other risks that you're not even aware of. And these are the hidden risks."[149] – Claassen

9. THINK FUTURE: "**None of the premiums for these plans are static.** They will increase over time to one degree or another. So, when you decide which plan is right for you, you need to consider the future cost and how it's going to impact your budget. . . You need to consider the potential future costs over 20 years and how this will impact your budget. How much the plan will increase includes geography ... the plan itself... [and] some insurance companies have higher and more persistence price increases."[150] – Claassen

10. PICK FOR LONG TERM: "**The number one most common mistake** I see is when a person looks at their current health situation and chooses a plan based on their current health. I can't count how many times I have heard: 'I am healthy. I never see a doctor, so I am just going to go with the cheapest plan that there is available.'

"**In all but a few states you can't change your Medicare supplement plan** once you've become critically or chronically ill. So, my advice is you should get the insurance that you will want to have when you're seriously ill and not whatever's cheap today because you're healthy."[151] – Claassen

"Choose a plan that fits comfortably in your budget, but "don't think of your supplement as a once-in-a-lifetime purchase. Think of it as making a best long-term decision that you can do when you first start Medicare. Then **re-shop your plan when you're between 72 and 75 years old** if you can pass underwriting. Often the insurance companies that offer you the lowest price when you're between 65 and 68 are not the best value plans when you're in your young or mid-70s. You will likely have an opportunity to reduce your cost significantly if you can qualify medically."[152] - Claassen

The following story, written in a comment on agent Brian Monahan's Medicare 365 video, showcases the importance of making decisions with the unforeseen future in mind:

> "In my second year on Medicare, I was diagnosed with breast cancer. Prior to that, I'd been the person who sees her primary once a year, and had a mammogram ... that was it for about the previous 20 years.
>
> Because I had chosen a Plan G, I was able to go out of my small city to a large cancer center near where my daughter lived. I had a total of 4 surgeries, 16 "rounds" of chemo, and 33 radiation treatments plus numerous visits. During the second type of chemo, visits were 3 times a week. The workup included a PET scan, CT, MRI, etc.
>
> "My total cost outside of the premium was the $203 deductible. If I had chosen an advantage plan, I would have had to stay in my area and undoubtedly would have hit my max OOP of over $6K on that plan. No question, for me, Plan G was the best.
>
> "I did compare F and G. F had no deductible, but the premiums were $400 more. G had a $203 deductible, so I was saving $197 with G....besides being advised that plan F costs could be expected to go up more than G as it would soon have only older people on that plan. And that gym membership on an advantage plan doesn't mean anything when you are so sick that you can barely get from the bedroom to the bathroom due to chemo!"[153]

That said, **Stephanie Abt** says there are downsides to Plan G, including that the rates will go up over time, usually every year. Second, Plan G's rate may increase more due to the plan being open under "guaranteed issue" for those who lose their Medigap coverage. Third, some agents only sell Plan G and don't share other choices. Fourth, Medigap plans do not cover most services not covered by Medicare.[154]

NOTE: Medigap plans have no annual open enrollment, but once you have one, they are guaranteed renewable for life—if you continue to pay your premium.[155]

11. ASK THE RIGHT QUESTION: Medicare's intent is to cover anything that is 'medically necessary.' Your Medigap policy will cover the copayments and the deductibles of all medical care approved by Medicare, and Medicare will cover whatever is considered medically necessary.

"So instead of thinking about your Medicare coverage in terms of WHAT is to be covered, look at the WHY," says Claassen. "Why is the procedure being done? What condition makes this procedure medically necessary? . . . There are certain steps that doctors may have to take to make something medically necessary" for a particular procedure or a test. You can't just walk into a doctor's office and get a brain scan because you want one.[156]

"INSTEAD OF THINKING ABOUT YOUR MEDICARE COVERAGE IN TERMS OF WHAT IS TO BE COVERED, **LOOK AT THE WHY**."

"The term 'medically necessary' is important. It's used consistently in your ***Medicare & You*** guidebook[157] when describing Medicare services. . .

"**So, how does Medicare determine medical necessity?** They lean on your doctors. It depends on your doctor's diagnosis and your doctor's opinion. .

"The bottom line is your supplement will cover the copays and deductibles of all of your health care approved by Medicare and Medicare will cover what is medically necessary."[158] – Claassen

Medicare rules underscore these comments: "The physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders test, drugs, and treatments, and determines the length of stay. Accordingly, sections 1814(a)(2) and 1835(a)(2) of the [Social Security] Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services." Other practitioners, such as nurse practitioners and physician assistants, are permitted to certify and recertify the need for post-hospital extended care services.[159]

12. DO THE MATH: The premium helps determine your choice. The monthly premiums of the alphabet of Medigap options may vary state to state. Thus, it is advisable to do the math to come to the best decision for you. Remember, **if you choose a high deductible Medigap policy, the maximum out-of-pocket for any given year is that year's deductible** ($2800 in 2024), which could increase over the 10, 20, 30 or more years you have it.

WHAT MEDIGAP COMPANIES SHOULD I AVOID?

In his ***"Medigap Supplement Hidden Risks Part 2"*** video, Claassen shares four rules he follows in advising his Medicare clients:[160]

1. AVOID all companies that have not been selling Medicare supplement plans for at least five years. (i.e. Avoid companies that are products of 5-year venture capital campaigns.)

2. AVOID the unknown or not nationally known companies that are selling the cheapest supplement plans in the age 65 to 68 age bracket — the cheapest plans can become the most expensive.[161]

3. AVOID companies with a lower than A minus rating with AM Best and if they have an S&P or Fitch or Weiss rating, it must have an investment grade, a BBB minus rating at a minimum. If it doesn't have an AM Best rating, avoid it. **IMPORTANT:** If the company is a subsidiary of a larger organization, it's the parent company's ratings that are the ratings of the smaller company.

4. AVOID regional companies. Many of these companies only do business in one state, he says, like Florida Blue. "They, as a rule, tend to have higher price volatility and may be targets of a buyout."

Speaking of regional companies, also in Claasen's November 11, 2023 *"Hidden Risks Part 2"* video was some interesting information about Blue Cross Blue Shield you may wish to investigate. Mr. Claasen said:

THERE ARE **34 DIFFERENT COMPANIES** THAT CALL THEMSELVES BLUE CROSS BLUE SHIELD

"Did you know that there's no big or national Blue Cross Blue Shield insurance company? Blue Cross Blue Shield is an association whose members pay to use their name. There are 34 different companies that call themselves Blue Cross Blue Shield. They're different companies, completely independent of each other. Different people, different home office, different corporate make up, different ratings, different everything. They simply pay the Blue Cross Blue Shield corporation money to use their name, logo, and such so that they look bigger than they are.

"And, of course, the association provides them information and guidance. I don't think it's a turnkey system, but it helps. Many of these companies only do business in one state, like Blue Cross Blue Shield of Alabama, or Arizona or Connecticut, Colorado, California, Florida Blue and so on.

"The largest of these companies is Anthem, which I think recently changed its name to Elevance, and is in 14 states, which is larger than the definition of regional, which I'm referring to. Other than Blue Cross Blue Shield, the companies that I refer to are usually active in only one, two, or maybe three states. The simple fact is that they, as a rule, tend to have higher price volatility and can be targets of buyouts for insurance companies that want to increase their exposure in whatever state they're in."

Other Medicare agents you talk with, or listen to, may have other rules they follow and give you varying opinions about Medigap options, including local, regional and national plans. Listen carefully and ask questions.

Ultimately, it is up to YOU to make the best decision for you with the advice of your licensed Medicare insurance agent (preferably independent). Asking a qualified insurance agent good questions that probe for information and insights is important. Go to **page 107** to find several questions to consider.

Your MEDICARE DECISION should be based on all the information you can gather from a variety of sources, including, but not limited to, the CCHF ***Medicare How-To Guide.***

ULTIMATELY, IT IS UP TO YOU, WITH THE ADVICE OF YOUR LICENSED MEDICARE AGENT, TO MAKE THE BEST DECISION FOR YOU.

High Deductible Medigap Policies

Is a high deductible Medigap policy worthy of your consideration?

The high deductible policy is typically the lowest cost Medigap policy. Before January 1, 2020, there were three versions of Medicare high deductible policies: F, G, and J. Today, unless you turned 65 before January 1, 2020, there is only one version available to you: **the G-High Deductible (GHD) policy.**

The G-High Deductible (GHD) Medigap policy has a deductible unlike any deductible you've experienced before. **IMPORTANT:** although it does not cover the cost of the Part B deductible, it credits payment of the Part B deductible toward the GHD deductible ($2,800 in 2024).[162]

With a high deductible policy, you will pay out of pocket bill by bill, service by service, until you reach the deductible ($2,800 in 2024). For example, the following numbers from **two different service charges come from the Explanation of Health Care Benefits** of a high deductible Medigap Plan G. The deductible amount is what the patient pays from each bill:

Service Charge	**$1944.00**	**$300.00**
Medicare Allows	**$309.48**	**$98.84**
Medicare Pays	**$246.58**	**$78.75**
Deductible Amount	**$62.90**	**$20.09**

The most popular Medigap policy is Plan G. This plan has no deductible and covers all out-of-pocket costs except the Medicare Part B deductible; however, its monthly premium is higher. Plan G "means that you won't pay anything out-of-pocket for covered services and treatments after you pay the [Part B] deductible."[163, 164]

A 2023 report funded by the Social Security Administration claims Plan F and G supplemental policies create "moral hazard," increasing medical consumption by its enrollees by $2,300 a year, and driving up costs because there are no bills for the enrollee to pay.[165] Whether you agree or not, unless the government eliminates this "no bills" option, the choice is still up to you.

SHOULD I PURCHASE A HIGH-DEDUCTIBLE MEDIGAP POLICY?

Independent broker **Matthew Claassen** has insights and valuable information on high-deductible Medigap plans, which are not as widely available. Below you'll find him quoted extensively. The following are several important points he has shared by video, including the risks and benefits of high deductible plans — plus two facts from CMS. **NOTE:** the quotes below include references to Plan F and Plan J, which are no longer available to people enrolling in Medicare after January 1, 2020.

• "**Without a Medicare supplement plan you have unlimited financial risk** . . . With the high deductible Medicare Supplement Plans your financial risk is limited to their annual deductible. . . Their function is to set an annual Maximum Out-of-Pocket [MOOP] limit on your Medicare".[166]

• **Medigap High Deductible polices are not like any other high deductible policy.** "The first thing you need to do is erase whatever preconceived notion that you have of the term 'high deductible.' The benefits of these high deductible plans will be unlike any of the other high deductible plans that you've experienced in your lifetime."[167] Medicare (Parts A and B) pays its 80 percent share. Then your Part B deductible, copayments, and coinsurance payments are applied against the deductible of the high deductible Medigap policy until the deductible is used up. Then Medigap begins to pay.

• "**The role of the Medigap high deductible plans is to provide a maximum annual out-of-pocket expense or cap on your medical expenses** . . . . Because Medicare still pays its portion, that [deductible] is really your maximum out-of-pocket for [the year]. . . When you purchase a Medicare Supplement High Deductible Plan you create a MOOP [Maximum Out-of-Pocket] equal to the plan's deductible."[168]

• "**Your insurance is Original Medicare** with a maximum annual cap equal to the Medigap plan's deductible. It's that simple. Your Medicare Supplement deductible is your maximum annual out-of-pocket risk."[169]

• " **The high deductible Medicare supplement is the only Medigap plan with its own deductible.** The other supplement plans may or may not cover one of the Medicare deductibles, but they don't have their own deductible. Still a Medicare supplement deductible has no impact on your Medicare. None. It does not create a high deductible for your Medicare. The high deductible is for your supplement only."[170]

• "**Medicare Part A and Medicare Part B will be your only insurance coverage up until you reach the amount of the deductible.** Once you reach the deductible you have 100 percent coverage for the rest of the calendar year. Medicare Part A and Medicare Part B still pay their portion first."[171]

• **The Centers for Medicare & Medicaid Services (CMS) reports:** "The deductible amount for the high deductible version of plans G, F and J represents the annual out-of-pocket expenses (excluding premiums) that a beneficiary must pay before these policies begin paying benefits."[172]

• **Cost-of-Living Calculation for 2024 Premium:** "The deductible for [the high deductible] plans F, G and J is determined in accordance with section 1882(p)(11)(C)(i) of the Social Security Act. This provision prescribed a deductible of $1,500 for 1998 and 1999 and directed that the amount increase each subsequent year by the percent increase in the CPI-U, all items, US city average. The increase in the applicable CPI-U from 2022 to 2023 is 3.67 percent, which results in a deductible of $2,800 after rounding to the nearest $10 in accordance with section 1882(p)(11)(C)(ii) of the Social Security Act." - Centers for Medicare & Medicaid Services (CMS)[173]

WHAT ARE THE RISKS OF A HIGH DEDUCTIBLE PLAN?

INFLATION: Consider inflationary increases. "**Of all the Medicare Supplement Plans, the high deductible plan is the most vulnerable to periods of high inflation,**" notes Claassen. "Because the increase in the deductible is a direct decrease in your benefit, periods of high inflation directly reduce the value of the high deductible plan compared to your other Medicare supplements."[174]

MORE FOR LESS? "If you have a high deductible plan with a price that increases every year and a deductible that increases every year with inflation, you have two components of your insurance that are compounding against you.[175] Every year you're paying more for less coverage. If you're just turning 65, you can have 20 or 30 years of negative compounding that you really must consider.

PRICE INCREASES: "I prefer the high deductible plans in states that have a mandate requiring that all Medicare Supplement Plans be priced as either Issue Age or Community Rated. In these states, there are often some insurance companies where price increases are few and far between," emphasized Claassen. "If you're with the right insurance company, price increases can be few and far between.

Otherwise, with the wrong insurance company you can still certainly experience regular annual price increases. Being with the right insurance company in essence neutralizes one of the two components that are compounding against you."[176]

"In states that price these plans as attained-age, where the price automatically increases a little bit each year as you attain an older age, the annual percentage price increase on a Medicare Medigap High Deductible plan is typically higher than the average annual percentage that you may find on a Plan N."[177]

"Many people researching Medicare for the first time falsely believe an Issue Age or Community rated policy equates to no price increases over time. That is not true." says Mr. Claassen. **"All and any Medicare Supplement Plans can have price increases.** There's no price structure that turns a for-profit insurance company into a philanthropic organization. All they have to do is apply to the state for a price increase in any type of Medicare supplement pricing structure."[178]

Stephanie Abt, broker at Abt Insurance, concurs, "In most places the rate type will be based on where you live. And really, one rate type isn't going to be better than another . . . **No matter which type of rate type you have, expect your rate to go up**."[179]

RATING DEFINITIONS:

COMMUNITY-RATED STATE: "This means, that everyone enrolled in the same policy pays the same premium, regardless of age, gender, or when the policy was purchased. Premiums can vary depending on where you live (urban or rural) and if you use tobacco products," reports the state of Minnesota.[180]

ISSUE-AGE STATE: "Issue-age-rated plan premiums are based on your age when you apply for coverage. Your premium rate will be lower if you sign up when you're younger than if you wait until you're older (at age 65 versus 70, for example). These rating plans also generally increase rates annually, but rate increases are not dependent on your age in the future like they are with attained-age premiums. Small percentage increases are based on inflation and other health care factors. Not every state offers issue-age-rated plans."[181]

ATTAINED-AGE STATE: The price of premiums automatically increases a little bit each year as you attain an older age.[182]

COMPOUNDING: "The compounding of the increase in price could have a significant negative affect over 20 or 25 years or longer," said Claassen, discussing the high deductible policies. Thus, if you live 25 years on Medicare, many years of cost-of-living increases will compound against you. At 2 percent inflation, the deductible will be $4,000; at 3 percent the deductible will near $5,000. Unlike any other Medigap plan, the value of a high deductible plan will go down during periods of high inflation.[183]

"If the annual premium is increasing in addition to the higher deductible, you have two parts of your plan compounding against you. This will leave you paying more each and every year for less insurance," Claassen warns.

SEQUENTIAL DEDUCTIBLES: "The Murphy's law" of the high-deductible, per Claassen: The calendar-year deductible also resets every January 1. If you get seriously ill late in the year, and you reach that deductible by year end but you're still sick, you may find yourself paying another deductible at the start of the new year. Thus, if you have a High Deductible Medigap plan you must have the resources to pay at least two years of deductibles.[184]

LOCATION MATTERS: "There are some parts of the United States where a Medicare supplement high deductible plan is a no-brainer. There are other parts of the country where it's such a poor value relative to your other Medicare supplement plans that it's simply not worth considering in most situations and most circumstances."[185]

WHAT ARE THE BENEFITS OF A HIGH DEDUCTIBLE PLAN?

EASIER TO MAINTAIN COVERAGE: Some seniors eventually find themselves priced out of their chosen Medigap policy. With high deductible plans, "the premium is very low." The rates will increase but are typically less than $100 a month and closer to $50. A lower premium means even in the worst of times you can maintain your Medigap coverage.[186]

MORE CASH FOR IMPROVED COVERAGE: Plan G high deductible policies free up money to build on your medical coverage. According to Mr. Claassen, the extra funds available due to the low-cost high deductible plan could be used to buy a supplemental insurance plan, such as a private cancer indemnity policy that will pay a lump-sum tax-free check of $25,000 to $35,000 to the patient if a patient is diagnosed with cancer. Dental, vision, and hearing coverage (real insurance) could be purchased and

may still save money over most of the other Medicare supplement plans. Thus, Claassen says, you can end up with a much broader, more comprehensive health coverage and still have less out-of-pocket costs than if you had a higher-cost Medicare supplement plan.[187]

LOWER OUT-OF-POCKET THAN MEDICARE ADVANTAGE: High deductible plans have low "maximum out-of-pocket" (MOOP) relative to Medicare Advantage plans – "While you would have more out-of-pocket risk relative to other Medicare supplement plans, the high deductible plan has an annual out of pocket exposure that is a third to one-fifth a typical Medicare Advantage Plan," says Claassen.

"Plus," he notes, "you keep the benefits of Original Medicare. So, a typical Medicare Advantage Plan PPO can have a maximum annual out-of-pocket, a MOOP, of between **$6,700 to $10,000** when you need medical services."[188] Medicare sets the amount. In 2024, the MOOP for Medicare Part C (Medicare Advantage) was $8,850 (maximum total for Part A and B charges).[189]

TWO CONSIDERATIONS

First, evaluate the price relative to other plans, particularly Plan N (lowest cost Medigap plan with full coverage). "When your out-of-pocket expenses during the average year of owning a Plan N is close to the ***worst-case scenario*** of a High Deductible Plan you should consider the high deductible plan," says Claassen.[190]

Thus, for a deductible Medigap plan to be a good value, the annual premium for the lowest cost of full coverage (Plan N) should be close to the maximum out of pocket (MOOP) of a high deductible plan. In 2019, Claassen explained the math one could use to make this decision. The numbers used in the example below are for 2020, not 2025, but his math is clear. Using direct quotes and paraphrasing, we present the math he suggests:

> For example, if your Medigap Plan N options are $180 a month in premiums, that's $2,160 a year in premiums even if you never see a doctor. If you do see a doctor, then you will pay the Medicare Part B deductible of $198 plus copays. So, you're looking at $2,500 out-of-pocket for the year. Compare that to the high deductible plan where the premium is typically between $600 and $850 a year and only in the worst-case scenario, **maybe once or twice in 10 years will you have enough medical expenses to reach that maximum** [deductible of] $2340.

So, the rule of thumb is when your out-of-pocket expenses during the average year of owning a Medigap Plan N is close to the worst-case scenario of a high deductible plan, you should at least consider the high deductible plan.[191] The following graph is using the 2020 example:

	PLAN N (average year)	HIGH DEDUCTIBLE (worst case)
Premium (annual)	$2,160	$850
Deductible (Part B)	$198	$198
Copays	$20 - $50 (per visit; no limit)	
Deductible (Medigap)		$2,340 (credits $198 Part B deductible)
TOTAL	$2358 PLUS COPAYS (NO maximum OOP)	$3,388 (maximum OOP)

NOTE: Only High Deductible Plan G, and Medigap Plans K and L have maximum out-of-pocket limits.[192]

Second, if you're in a state with a "high deductible plan in either an issue-age or community-rated state. . . In those states, unless you're with the wrong insurance company, price increases are few and far between. There is no automatic annual price increase," says Claassen.[193]

REMINDER: PLEASE CONTACT A REGISTERED INSURANCE AGENT WITH KNOWLEDGE OF THE CURRENT MEDICARE OPTIONS AVAILABLE TO YOU IN YOUR GEOGRAPHIC AREA.

Health Care Sharing Ministries

Health care sharing is not health insurance and does not count as "creditable coverage" under Medicare rules. However, health care sharing ministries (HCSMs) continue to offer an alternative form of coverage for Americans aged 65 and older.

According to Investopedia, "Health Care Sharing Ministries (HCSMs) are groups whose members share religious or ethical beliefs and contribute a monthly amount that is, in turn, used to pay for the medical costs of other members. They aren't insurance companies and don't provide health insurance in any form."[194]

Members of health care sharing ministries typically must submit their own bills for reimbursement to the HCSM, according to the ministry's rules.

At least one health care sharing ministry (HCSM) does not require senior citizens to enroll in Medicare at age 65. **Samaritan Ministries**—which began in 1994 with ten families sharing medical needs and now orchestrates the sharing of over $30 million in medical expenses each month — offers coverage beyond age 65.

HCSMs ARE GROUPS WHOSE MEMBERS SHARE RELIGIOUS OR ETHICAL BELIEFS AND CONTRIBUTE A MONTHLY AMOUNT USED TO PAY FOR THE MEDICAL COST OF OTHER MEMBERS.

Samaritan members who choose to enroll in Medicare (for example, to be able to access their Social Security benefits), must first submit medical bills to Medicare before submitting the remainder to Samaritan for sharing.

NOTE: Under federal law, health care sharing members are excluded from the health insurance mandate in the Affordable Care Act. Though relatively unknown, **the health insurance mandate remains in federal law**; the penalty was reduced to zero dollars, so the mandate is currently unenforceable.[195]

HOW MANY HEALTH CARE SHARING MINISTRIES ARE THERE?

As of 2021, there were 107 health care sharing ministries certified by the U.S. Department of Health and Human Services.[196] As of December 2023, 1.7 million Americans were using health care sharing.[197] Some of the more prominent ministries are:

- **CHRISTIAN HEALTHCARE MINISTRIES**
- **LIBERTY HEALTHSHARE**
- **MEDI-SHARE**
- **SAMARITAN MINISTRIES**
- **SOLIDARITY HEALTHSHARE**
- **ZION HEALTHSHARE** [198]

HOW DO I CHOOSE A HEALTH CARE SHARING MINISTRY?

Each ministry is different. Each has a different set of publicly available guidelines, which include the ministry's rules about Medicare. Contact a health care sharing ministry directly to see if it is a good fit for you. Some HCSMs cover services and costs not covered by Medicare.

WHEN DO I ENROLL?

Any time before or after becoming Medicare-eligible. Some individuals simply maintain the membership in the health care sharing ministry they had before they became eligible for Medicare.

DO I HAVE TO ENROLL IN A HEALTH CARE SHARING MINISTRY?

No, it is a personal choice. In addition, there are no penalties for not choosing to enroll in an HCSM. We recommend that you speak with the ministry you're interested in to see how it may interact with your other Medicare choices.

HOW MUCH DOES IT COST?

Each HCSM has its own set of costs and sharing rules. **HealthShare Guide published a list** of the 10 best health care sharing ministries with costs, co-shares, and membership fees.[199]

WHAT IS MY NETWORK? (I.E. WHICH HOSPITALS/CLINICS CAN I GO TO?)

HCSMs rarely have network limitations for hospitals, clinics, and doctors or other providers. Some ministries may have a preferred provider list that offers discounted charges.

HOW DOES HEALTH CARE SHARING WORK WITH MEDICARE?

To find out whether a HCSM will share medical bills not covered by Medicare, check out the ministry's website and its guidelines. For example, **Samaritan Ministries'** website states: [200]

> "[Y]ou are not required to get any supplement or any part of Medicare, and Samaritan Ministries has been meeting the medical needs of those over 65 for as long as we have existed . . . . Some members opt out of Medicare altogether, some sign up for A & B, and many opt for only A."

But if a Samaritan member has enrolled in Medicare, the website notes: [201]

> "Medical bills must be submitted to Medicare, and any other payer who may be responsible, before submitting them to Samaritan Ministries. Members must receive either notice of payment or rejection and submit documentation before Samaritan Ministries will consider sharing the need."

Medi-Share, another health care sharing ministry, offers a Medigap-like supplement plan. **Medi-Share 65+** costs $99/month for enrollees aged 65 to 74. For individuals 75 years of older, the cost is $150, which can be locked in for 10 years. Medi-Share describes how it works:

> "Once you have met your $500 Annual Household Portion (the portion of your bills that you are responsible for), 100 percent of your Eligible Medical Bills (that Medicare does not pay) will be shareable by your fellow Medi-Share members."[202]

TRICARE for Life and Medicare [203]

TRICARE is a health care program for active-duty and retired uniformed services members and their family. TRICARE for Life is expanded medical coverage available to Medicare-eligible uniformed services retirees aged 65 or older, their eligible family members and survivors, and certain former spouses. Concerned that some members of the military are being misled, independent health insurance broker Matthew Claassen has sage advice for TRICARE for Life members:

KEEP ORIGINAL MEDICARE: "If you have TRICARE for Life or CHAMP VA . . . keep your TRICARE or CHAMP VA and keep your Original Medicare. Do not trade your Medicare in for a Medicare Advantage plan. Do not trade your TRICARE or CHAMP VA in for a Medicare supplement. And do not get a standalone Medicare Part D Plan especially if you have CHAMP VA.

https://www.youtube.com/watch?v=AWVDpE4CqNI

"I believe you cannot improve on your health care by messing with your TRICARE. If you replace your Original Medicare with an Advantage Plan, you're actually reducing your insurance coverage and potentially increasing your financial risk. That's the short answer and that's my firm opinion."

"TRICARE FOR LIFE IS LIKE A MEDICARE SUPPLEMENT PLAN **ON STEROIDS.**"

BETTER DRUG COVERAGE: "TRICARE for Life is like a Medicare Supplement Plan on steroids. In addition to the standard Medicare Supplement benefits, your TRICARE includes prescription drug coverage. You do not want to get a separate Medicare Part D plan. In fact, doing so can cause harm to your TRICARE especially if you have CHAMP VA, so be careful with that. By the way, did you know that the drug coverage you have through TRICARE is not subject to the gap, the donut hole that is a feature of the Medicare prescription drug coverage? You have no coverage gap, no donut hole with your TRICARE for Life prescription drug coverage." ***[Update: The Inflation Reduction Act of 2022 eliminated the Medicare Part D donut hole, starting in 2025.]***

OVERSEAS COVERAGE: "One of the enhanced benefits ... about TRICARE is that it offers significant health care coverage overseas. Medicare only operates in the U.S. and the U.S. territories. Some Medicare supplement plans offer limited emergency coverage if you're overseas. A few Medicare Advantage plans do as well, but that's quite unusual with them .... [When overseas] TRICARE for Life becomes your primary insurer. It's very cool."

TWO LOSSES: "When you trade in your Original Medicare for a Medicare Advantage plan, you lose the two benefits of Original Medicare...First, you can no longer see any medical provider in the U.S. as long as they accept Medicare. You will now be limited to the Medicare Advantage plan network of providers. The providers you see have to have signed a contract to accept your specific Medicare Advantage plan. Seeing providers out of network can be cost prohibitive or simply not allowed by the Medicare Advantage plan.

"Second, instead of your health care decisions being between you and your doctor, it's now the insurance company who directs your health care. Now that's important. Your doctor will have to get permission from the insurance company for any procedure or treatment. The insurance company can deny the procedure or delay the procedure by up to two weeks. I've seen this done for urgently needed chemotherapy and even dialysis or therapy after a stroke. It could be anything."

PAPERWORK BURDEN: "Unlike when you have Original Medicare and TRICARE, when you have an Advantage plan, you will have to pay the claim and then submit the paperwork to TRICARE for reimbursement. To be clear, when you have a Medicare Advantage plan anything that TRICARE would pay you must pay first and then be reimbursed. It's not automatically paid for like it is when you have Original Medicare."

DUPED: "Retired veterans who have been switched from Original Medicare to a Medicare Advantage plan are . . . a significant percentage of Medicare complaints. Once they use the Advantage plan and realize that their benefits have been reduced from what they've had, they often complain to Medicare that they've been duped."

DENTAL COVERAGE: " TRICARE for Life is designed to work hand and glove with Original Medicare. You cannot improve on that, except to get dental coverage. You can get that through TRICARE as well and there are literally dozens of dental plans or standalone dental plans that are available to you as well."

RUN AWAY: "If you trade in your Original Medicare A and B for an Advantage plan you reduce your health care coverage and lose the greatest benefits of Medicare. In addition, anything that TRICARE would pay for you, you will then have to pay up front and submit paperwork for reimbursement. In my opinion if you come across an agent that's trying to replace your Original Medicare with a Medicare Advantage plan, run away. They are either ignorant or simply care more about their commissions than your health care."

APPRECIATIVE AGENT WEBSITE COMMENT TO CLAASSEN: "Thank you for making this video. I've been specializing in helping people navigate Medicare for over 16 years. When I go into someone's home, and they tell me they have TRICARE, I thank them for their service, and then I spend the next hour explaining to them why they don't need anything else — with the exception of Medicare Part A and B."

10 Medicare Traps

The Medicare program has various traps from which it is difficult, if not impossible, for Americans to escape if they're caught unaware. Some are obvious, others are more hidden, like the Medicare program itself. The following are 10 traps we discovered in our research. There could be more.

1. **The Medicare Program**
2. **No Other Coverage Options**
3. **Financial Penalties for Delayed Enrollment**
4. **Medigap Rule Restrictions**
5. **Hidden Medigap Traps**
6. **Medicare Advantage Organizations**
7. **Workers Pay Higher Premiums**
8. **On the Hook for Stays at Hospitals and Skilled Nursing Facilities**
9. **Government Recipients Under Surveillance**
10. **Access to Drugs Limited by Part D Options**

TRAP 1 – THE MEDICARE PROGRAM

Under the 1965 federal Medicare law, most senior citizens are forced into Medicare when they reach the age of 65. Verywell Health explains: "You have to enroll in Medicare Part A or you forfeit your Social Security benefits. Most individuals are unwilling to forfeit their Social Security benefits, and thus accept the enrollment into Medicare."[204]

How did this happen? In 1993, the Clinton administration quietly changed the program operations manual of the Social Security Administration (SSA). The new instructions ***forced seniors to enroll*** in Medicare Part A (hospitalization) to receive their Social Security Retirement Benefits.[205] It's not a law.

Congress never mandated this change in operations, nor did an agency propose a rule for notice and public comment.

The revised SSA manual also added **penalties for seniors who choose to disenroll** from Medicare, forcing them to repay all benefits they have ever received from Medicare and Social Security.[206] Thus, most seniors are stuck in Medicare.

A GROUP SUED THE GOV'T IN 2008 FOR THE RIGHT TO OPT-OUT FROM MEDICARE, **BUT WERE THWARTED** BY A 2012 APPEALS COURT.

A group of Medicare recipients sued the federal government in 2008 for the right to opt-out (disenroll) from Medicare — ***Hall vs. Sebelius***. They were thwarted by a 2012 appeals court ruling which claimed that federal law gave them no right to "un-entitle" themselves from Medicare. That was never the question. Judge Karen Henderson wrote a **brilliant dissent** against the ruling.[207] However, in 2013, the U.S. Supreme Court refused to take up the case.

Seniors are also forced into Medicare by financial penalties. If they refuse to enroll, and later change their mind, a lifetime of financial penalties awaits, as described earlier in this guide.

Seniors also face few options for coverage. **"Prior to the Affordable Care Act (ACA), individual market insurers typically wouldn't insure anyone over the age of 64, so plans were automatically terminated when people turned 65,"** reports Verywell Health.[208]

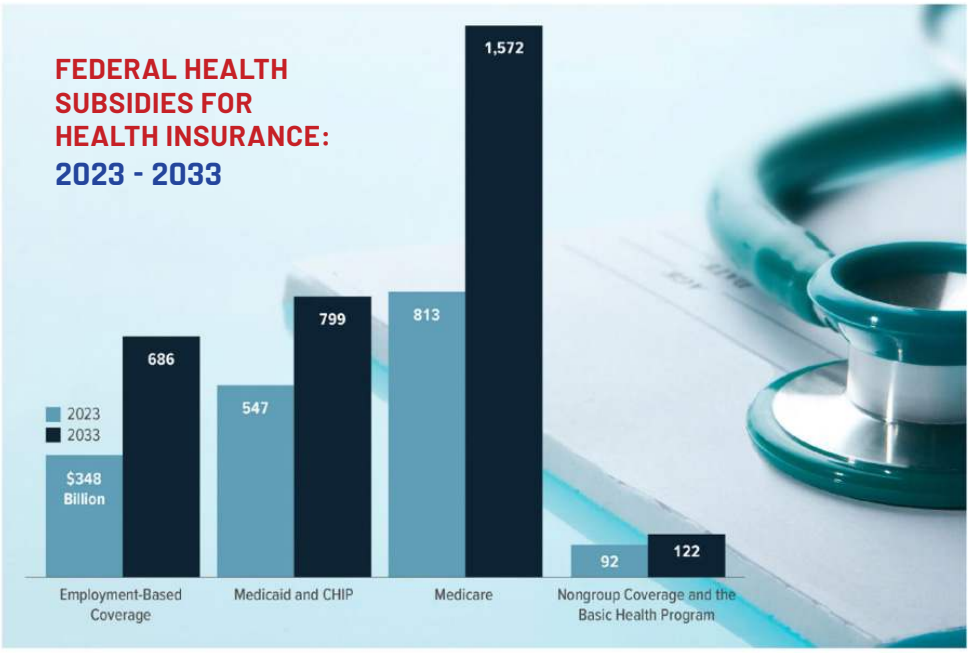
While individuals are not forced off the ACA "marketplace," federal subsidies for Obamacare coverage, including premium tax credits, end when Medicare begins. If individuals fail to disenroll from Obamacare, they will pay the full cost for both programs: Medicare as primary payer and Obamacare as secondary coverage.[209]

While no law prohibits the sale of private coverage to people ages 65 and older, access to private health insurance as primary coverage is all but impossible to buy. Both Obamacare coverage and employer-sponsored coverage for retirees become the secondary payer.

TRAP 2 – NO OTHER COVERAGE OPTIONS

Medicare is a Ponzi scheme and it's going broke. According to the Medicare Trustees, insolvency is expected in 2036.[210] The Congressional Budget Office (CBO) in 2023 estimated 73 million enrollees by 2033.[211] Meanwhile the actuaries in the Medicare administration estimate 77.7 million Americans will depend on the program by 2032.[212]

Whatever the real number, the cost to American taxpayers is enormous. The CBO chart **below** on federal subsidies is in billions of dollars. It estimates Medicare subsidies in 2033 to be $1,572,000,000,000 — $1.5 trillion. With looming insolvency and no other options for medical coverage, what kind of care will senior citizens in America receive?

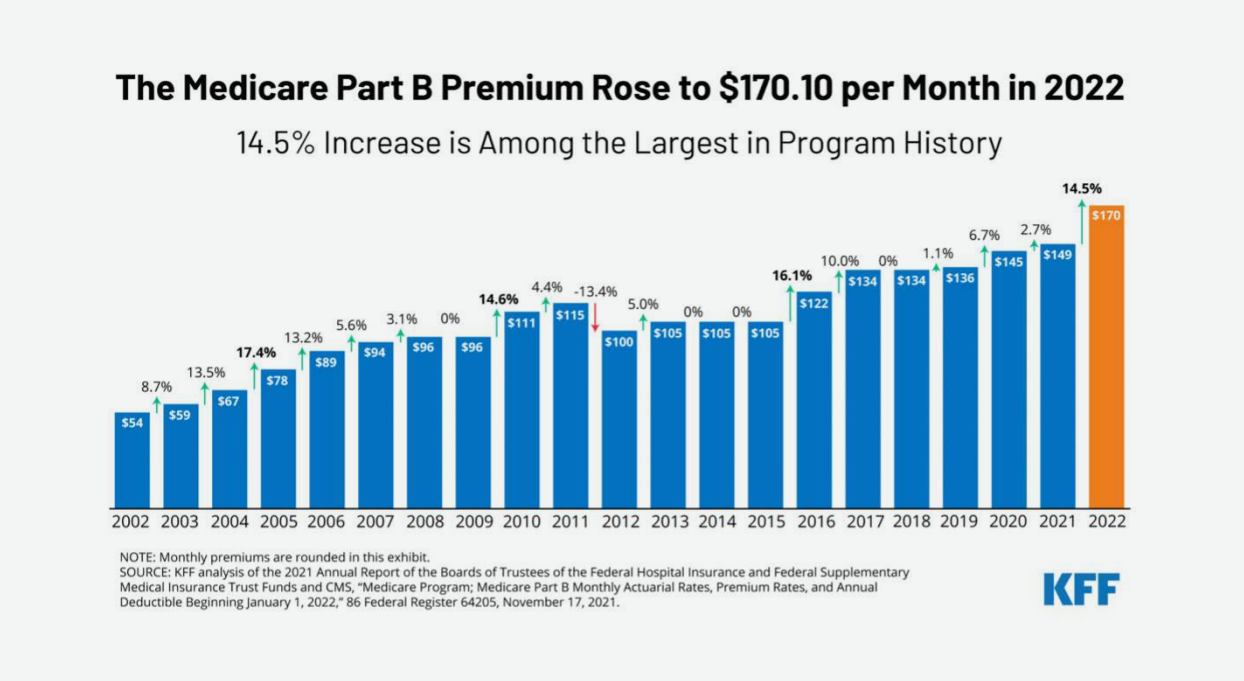


Many senior citizens believe they fully paid for their Medicare. This is not true. According to a 2019 *Harvard Business Review,* beneficiaries pay only a fraction of their cost for medical care: "Each beneficiary on average receives $310,000 more in benefits than they paid."[213, 214] Has that number grown in five years?

An astonishing 10,000 baby boomers enter Medicare every day expecting it to be there for them and having no other coverage options as federal officials continue to issue reports of Medicare health plans rationing care to seniors.[215]

10,000 BABY BOOMERS **ENTER MEDICARE EVERY DAY** EXPECTING IT TO BE THERE FOR THEM.

Meanwhile, Medicare premiums escalate. In 2002, the monthly premium for Medicare Part B was $54, for a total of $648 per year. In 2024, the monthly premium is $174 for a total of $2088 per year, an increase of 332 percent over 22 years, paid mostly by seniors on limited incomes. Working seniors, or seniors with higher incomes, pay even higher premiums.[216]



With no other coverage options, seniors are locked into the federal government's soon-to-be-bankrupt Medicare program, unless they have the means to pay cash for all their care — a rare person, indeed — or are eligible to join a health care sharing ministry. ***See details on page 57.***

TRAP 3 - FINANCIAL PENALTIES FOR DELAYED ENROLLMENT

Your first enrollment decision (and the timing of that decision) is very important. Delayed enrollment could lead to temporary or permanent financial penalties—or permanently limit your enrollment choices.

Medicare imposes significant penalties for those who delay enrollment. Find details in the descriptions of each Medicare Part above. But in short, these are:

- **MEDICARE PART A (hospitalization)** – a 10 percent penalty for twice as many years as you were eligible but did not choose to enroll
- **MEDICARE PART B (outpatient care and clinic visits)** – lifelong penalties based on each 12 months of delay in enrollment
- **MEDICARE PART D (drug coverage offered by private entities including health plans)** – lifelong penalties based on each month of delay in enrollment

TRAP 4 – MEDIGAP RULE RESTRICTIONS

During your initial enrollment period, unless you choose to enroll only in Part A, you must decide between Original Medicare and Medicare Advantage. Original Medicare includes Part B.

The first six months (typically 180 days) after the date you enroll in Medicare Part B—your "Part B date"—is **the one time you can choose a Medigap policy without facing medical underwriting**—unless your Medigap insurance company discontinues your policy. This six-month period, which begins on the first day of the month that you are both age 65 and enrolled in Part B, is called the Medigap Open Enrollment Period.

Medigap is only available to those in Original Medicare. If you choose Original Medicare, you may opt to purchase Medigap coverage to cover out-of-pocket expenses not covered by Medicare (copayments, deductibles and coinsurance).

After the initial six-month period, Medigap companies **may refuse your request** for Medigap coverage if they determine through medical underwriting (e.g. health questionnaires, review of medical records) that you will be or could become a financial burden to them. Alternatively, they may offer you Medigap coverage at higher or unaffordable prices. Thus, the switch from Medicare Advantage to Original Medicare may be ***financially infeasible***.

> "**When anyone has to go through medical underwriting**, it's the one opportunity that an insurance company has to filter out the people whose health profile shows an expense ratio that will be a burden on their prices. In other words, they need to keep out people whose health costs are going to put pressure on the pricing. Underwriting questions are completely different from one company to another and even from one state to another," says Michael Claassen, CEO, MedigapSeminars.org[217]

What about pre-existing conditions? During the initial enrollment period, you cannot be denied for preexisting conditions. However, "If you're changing [Medigap] policies, as long as you do not have a gap in coverage of more than 62 or 63 days, and you've held your current policy for at least six months, there can be no pre-existing condition clause in the new policy."

Bottom line: while you can always switch from Original Medicare to Medicare Advantage, and from one Medicare Advantage plan to another, some may find it nearly impossible to leave Medicare Advantage due to Medigap restrictions. If you have pre-existing medical conditions that cause a Medigap insurer to decline coverage, Original Medicare may be out of reach.[218] Similar to the lyrics of ***Hotel California***, "you can check out any time you like, but you can never leave." (The Eagles, 1976)

TRAP 5 – HIDDEN MEDIGAP TRAPS

As we conducted research for this guide, using government websites, news, YouTube, and other resources, we discovered several less than obvious Medigap traps. Here are three for your consideration. There may be more.

1. PRICED OUT – Some seniors have dropped their Medigap policy after years of payment because the premiums continued to rise while their incomes did not. They then became responsible for all future copayments, deductibles, and coinsurance, unless another Medigap plan would accept them, or they switched to Medicare Advantage, where they would also face copays, deductibles, coinsurance, restrictive networks, a higher maximum out of pocket—and likely denials of care. *See Trap #6.*

2. LIMITS ON GUARANTEED ISSUE – If a policy is discontinued by a Medigap company, the enrollees can choose another Medigap policy without facing medical underwriting. Their health history cannot be used against them. This is called "guaranteed issue."

However, the lowest-cost comprehensive Medigap policy, **Plan N**, which requires a monthly premium plus a $20 or $50 copay per visit (clinic vs. emergency room respectively) is not available under guaranteed issue. It is only available without medical underwriting in the initial Medigap Open Enrollment Period – the first six months after enrolling in Medicare Part B.

3. "CLOSED BOOK OF BUSINESS" – Some Medigap companies close their policies to further enrollment, trapping current enrollees in "death spiral" of rising prices as one by one enrollees are phased out due to death or discontinued enrollment. Because the company did not discontinue the policy, enrollees cannot switch to another Medigap policy under guaranteed issue.[219, 220] If the enrollees choose to leave the Medigap plan due to rising costs, they could be left with no Medigap options.

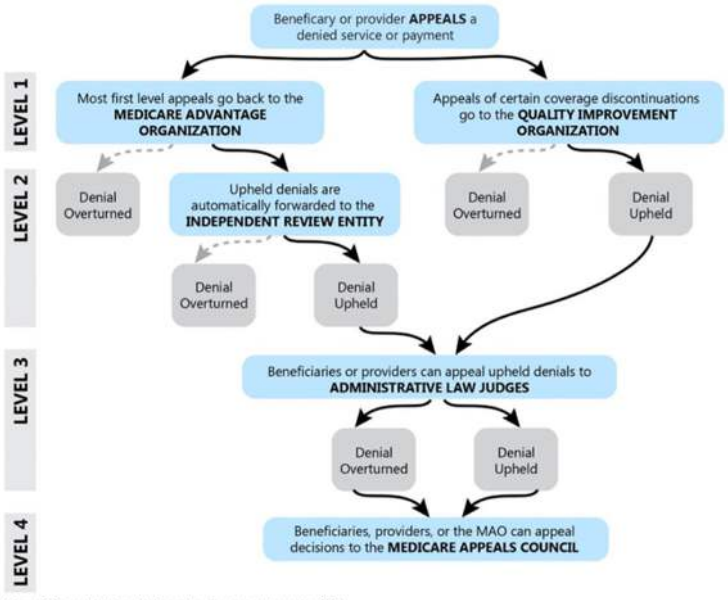
TRAP 6 – MEDICARE ADVANTAGE PLANS

The federal government is providing financial incentives for seniors to choose Medicare Advantage health plans despite its own ongoing evidence of the rationing of medically necessary care to seniors.[221]

A 2018 HHS Office of Inspector General (OIG) report found Medicare Advantage plans overturn their denials of care (or denials of payment) 75 percent of the time — if the denial is appealed.[222] However, **only 1 percent of denials are appealed**, making it highly lucrative for health plans to simply deny prescribed care and wait to see who appeals.

The OIG calls the appeals process a burden for seniors, who may be incapacitated or incapable. The following diagram displays the complex appeals process:[223]

Exhibit 1: Beneficiaries and providers can appeal Medicare Advantage denials to multiple levels of review within the Department of Health and Human Services.



Source: OIG analysis of the Medicare Advantage appeals process, 2018

If you choose Medicare Advantage, the government pays a fixed rate to the health plan to cover your medical expenses.[224] The plan, which then bears the cost of all your care, is in control of both your coverage and care – a conflict of interest. The health plan is allowed by law to delay or deny medical care using prior authorization.[225] To be assured that the treatment they want to give the patient will be paid for, practitioners must seek permission (authorization) from the health plan before providing it.

Medicare is a lucrative program for health plans. According to the 2023 *Medicare Trustees Report*, Medicare Advantage plans get up to 15 percent more per Medicare Advantage enrollee than is paid for senior citizens enrolled in Original Medicare.[226]

With the extra federal funds — a total of $83 billion expected in 2024[227] — health plans can offer "**$0 Premium**" plans and freebies such as SilverSneakers®, eyeglasses, dental care, and "free" over-the-counter items. It can also pay Medicare agents up to $1,300, including bonuses,[228] to encourage you to choose Medicare Advantage, despite it possibly being to your disadvantage.

However, if you need medical care — the purpose of having insurance — you may be limited to doctors and hospitals in the plan's network, and sometimes only those in your state.[229] Your access to a broader network, without out-of-network penalties, may depend on whether you choose the more restrictive HMO or the less restrictive PPO version of Medicare Advantage.

Denials of care, and payment for care, are common. As Kenneth Williams, CEO of Alliance Health Care told NBC News in October 2023:

> **"They don't want to reimburse for anything — deny, deny, deny ..... They are taking over Medicare and they are taking advantage of elderly patients."**[230]

Denials may also come through various federally approved notices, such as the Hospital-Issued Notice of Noncoverage (HINN) for those covered by Medicare Advantage or Original Medicare whose care no longer qualifies for coverage, and the Notice of Medicare Non-Coverage (NMNC) to Original Medicare beneficiaries when their Medicare covered services (s) are ending. The list of beneficiary notices with explanations can be found on the CMS website under "Beneficiary Notices Initiative (BNI)."[231]

Denial is not the only problem you may face. In 2024 alone (as of July 23rd), fifteen health systems had dropped Medicare Advantage. For example, Brookings Health System in South Dakota stopped accepting all Medicare Advantage plans.[232]

In January 2024, 62 percent of health system chief financial officers surveyed said getting reimbursed by Medicare Advantage is "significantly more difficult" than it was two years ago.[233]

Your only option in these situations, beyond using the appeal process *(see page 69)* is to wait for open enrollment. At that time, you can switch to a new Medicare Advantage plan in hopes of getting the care you need. You may also switch to Original Medicare, with or without the option of a Medigap policy. Only you can decide if the lower price of Medicare Advantage is worth the risk of care being denied or delayed.

NOTE: While there is an appeals process for Original Medicare,[234] we found no OIG reports of ongoing denials. However, we found a nationwide lawsuit against hospitals that admitted patients as hospitalized inpatients and later ***reclassified*** them as "outpatients." This change meant Medicare Part A (hospitalization) did not pay the cost of hospitalization,[235] putting patients on the hook for the 20 percent cost of Part B coinsurance, if it was not covered by their Medigap policy.

TRAP 7 – OLDER WORKERS MAY PAY HIGHER PREMIUMS

Some working senior citizens are not only forced into Medicare, they must also pay higher premiums because they are working.

SOME SENIORS MUST PAY **HIGHER PREMIUMS** BECAUSE THEY ARE STILL WORKING.

If you work for an employer with less than 20 employees, even if you have great health insurance through work or on your own, you are forced to join Medicare at age 65 or face a lifetime of Medicare penalties. If your income is high enough, you'll also be forced to pay higher Medicare Part B and Part D premiums.[236] This is called the Medicare income-related monthly adjusted amount, or IRMAA (pronounced "ur-ma"). If your annual income during the previous two years meets certain income thresholds, this surcharge is added to your monthly Medicare Part B and Part D premiums.[237]

If you or your spouse have coverage through an employer with 20 employees or more, you are allowed to work past the age of 65 without being forced into Medicare – unless you want your Social Security retirement benefits. *See Trap #1.*

TRAP 8 – ON THE HOOK FOR HOSPITAL AND SNF STAYS

BENEFIT PERIODS: Original Medicare covers a limited number of days in the hospital — 90 days per benefit period per year. Review the definition of "benefit period." See KEY TERMS. Every day you stay hospitalized after 90 days in the same benefit period increases your out-of-pocket costs – unless you have a Medigap policy to cover those days. A second benefit period for the year begins only after you've stayed out of the hospital 60 consecutive days.

If physicians think you won't be able to pay the bill, this payment scheme may encourage them not to admit you until 60 consecutive days have elapsed, even if it would be the best thing to do.

LIFETIME RESERVE DAYS: Original Medicare also provides only 60 Lifetime Reserve Days — for the rest of your life. If you live to age 95, that's only two reserve days per year. Per Medicare:

> You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.[238]

Read the hospital's consent-for-treatment forms carefully, and seek legal advice as needed.

If it includes language asking you to sign away those once-in-a-lifetime 60 days, consider not signing that part of the form. You have a choice. You do not have to use them, but if you exceed 90 days during the benefit period, you must either use them or pay the bill in full. If you want to be in control of those days, put your refusal in writing and tell them to get specific consent from you (or your power of attorney) for each lifetime reserve day they want to use. Take a photo of the document for your protection.

OUTPATIENT STAYS: You could also get stuck with unpaid bills for hospital outpatient stays and for stays in skilled nursing facilities, otherwise known as SNFs (pronounced "sniffs"). Take care to understand the Two-Midnight-Rule, the 3-Day Rule, and the importance of an ***inpatient stay*** rather than an outpatient or observation stay. See KEY TERMS. Inform your family members in case you cannot advocate for yourself. **Seek legal advice as needed.**

"An inpatient hospital stay begins the day the hospital admits you as an ***inpatient*** based on a doctor's order and doesn't include the day you're discharged,"[239] according to Medicare. Thus, you must be in the hospital for at least ***three nights classified as an inpatient***. In addition, Medicare Advantage "may have different rules for SNF coverage after you leave the hospital."[240]

IMPORTANT: "Each day you have to stay, you or your caregiver should always ask the hospital and/or your doctor, or a hospital social worker or patient advocate if you're an inpatient or outpatient," advises Medicare.gov.[241]

In short, if a stay, even an extended stay in a hospital is ***classified by the hospital*** as 'outpatient observation,' the stay does not qualify for payment by Medicare Part A (hospitalization). An outpatient or outpatient observation stay is covered under Medicare Part B (medical insurance), even if you're staying in a hospital. This classification will require you to foot 20 percent of the bill regardless of how high it goes unless the bill is covered by a Medigap policy – or if you're a "Qualified Medicare Beneficiary" through your state Medicaid program. QMBs can't be billed for Part A or Part B deductibles, coinsurance, and copayments.[242]

In addition, an outpatient classification may prevent you from getting Medicare payment for transfer to a skilled nursing facility (SNF). The 3-day inpatient hospitalization requirement prior to admission into an SNF may not be met.[243]

CHARGED TO STAY BEYOND DISCHARGE DECISION: "If you're admitted to a hospital as a Medicare patient, the hospital may try to discharge you before you're ready. While the hospital can't force you to leave, it can begin charging you for services," reports ElderLawAnswers.

You can appeal the discharge decision using a phone number on the form the hospital gives you called ***"Important Message from Medicare about Your Rights (IM)"***. The hospital will have you read the notice, sign it, and date it. This form must be given to you after admission and again before discharge.

On the form is the phone number for the local **Medicare Quality Improvement Organization** (QIO), a federally funded organization that is not affiliated with the hospital or health plan. We suggest you go to ElderLawAnswers to read their suggested process, but here is an abbreviated version:

- Get the QIO number from the IM form
- Call the QIO by noon on the first business day after you receive the discharge to avoid being charged on the third day after you receive the notice.
- After you request QIO review, the hospital must give you a "Detailed Notice of Discharge" explaining the medical reason for the discharge.

- Wait as QIO reviews the discharge decision (QIO must deliver their decision within three days).
- If you disagree with the QIO decision, you can ask it for reconsideration.
- If you still disagree with the QIO, options include appeals to an administrative law judge, the HHS Departmental Appeals Board, and/or a federal court.
- You may also seek legal counsel to assist with this process.[244]

NOTE: According to ElderLawAnswers, while the QIO is reviewing the discharge decision, you cannot be discharged, and you will not have to pay for the additional days in the hospital.

IMPORTANT: Medigap policies protect against high out-of-pocket hospital bills. As Medicare Interactive states: "Medigap policies A through L pay for your hospital coinsurance and provide up to an additional 365 lifetime reserve days. In addition, Plans B through J will pay your full hospital deductible."[245]

TRAP 9 – SURVEILLED AND EXPLOITED

When you enroll in Medicare you become a subject of surveillance. The federal government, which is on the hook for the cost of your medical care, now has a vested interest in everything that has happened, is happening, and will happen to you—as well as everything that was wrong, is wrong, and could be wrong with you physically, mentally, emotionally, and behaviorally.

Furthermore, many Medicare Advantage (MA) plans exploit patients for their own purposes. Using clinic questionnaires and home visits, they use a coding system to make their enrollees look as unhealthy as possible. The higher the patient's "risk score," the larger the government's "risk adjustment" payment to the health plan. With that in mind, read the following from Health Payer Intelligence:

> "Between 2007 and 2023, MA coding intensity generated nearly $124 billion in excess payments," the MedPAC researchers found.[246]

This exploitation and loss of medical privacy is just one reason you may wish to find a cash-based, independent doctor that does not accept government or insurance payments. Look for an independent, direct-pay practice at JointheWedge.com, CCHF's online directory of cash-based practices.

TRAP 10 – ACCESS TO DRUGS LIMITED BY PART D OPTIONS

According to the CDC, 71.9 percent of physician visits involve drug therapy.[247] In 1988, Congress added outpatient drug coverage to the Part B program. The dramatic increase in premiums led Congress to repeal outpatient drug coverage in 1989. However, in 2003, Congress created a new program called Medicare Part D – the largest expansion of Medicare since its creation in 1965. These subsidized plans are offered only by private corporations and almost every American will be forced to buy one at age 65.

Under Medicare rules, if a person does not have "creditable drug coverage" he or she must buy a Part D plan from a health plan or other government-approved entity, or face lifelong penalties if they later decide to enroll in Part D.[248]

Part D plans are not individualized to each patient's needs. The plan's drug formulary is often not comprehensive. While they must stay within certain guidelines, corporations that offer Part D plans have the power to limit the medications available to patients.[249] They may switch allowable drugs each year (or even mid-year) to fit their bottom line. We discovered some plans may not include common medications, such as certain inhalers for asthma or medicated creams and prescription ointments.

Medicare recipients must annually re-evaluate their Part D decisions and make changes as necessary. Patients can also appeal restrictions on covered drugs.

Here is the appeal process, per Medicare.gov:[250]

Get a written explanation (called a **coverage determination**) from your Medicare drug plan. A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your benefits, including whether a drug is covered, whether you've met the requirements to get a requested drug, how much you pay for the drug and whether the plan will make to an exception to a plan rule when you request it.

If your network pharmacy cannot fill a prescription, the pharmacist will show you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't show you this notice, ask to see it.

"Your doctor or other prescriber (for prescription drug appeals) can request this level of appeal for you, and you don't need to appoint them as your representative," per Medicare. Your Medicare drug plan will send you a written decision. If you disagree with this decision, you have the right to appeal.

The appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal."[251]

LEVEL 1: Redetermination from your plan [252]

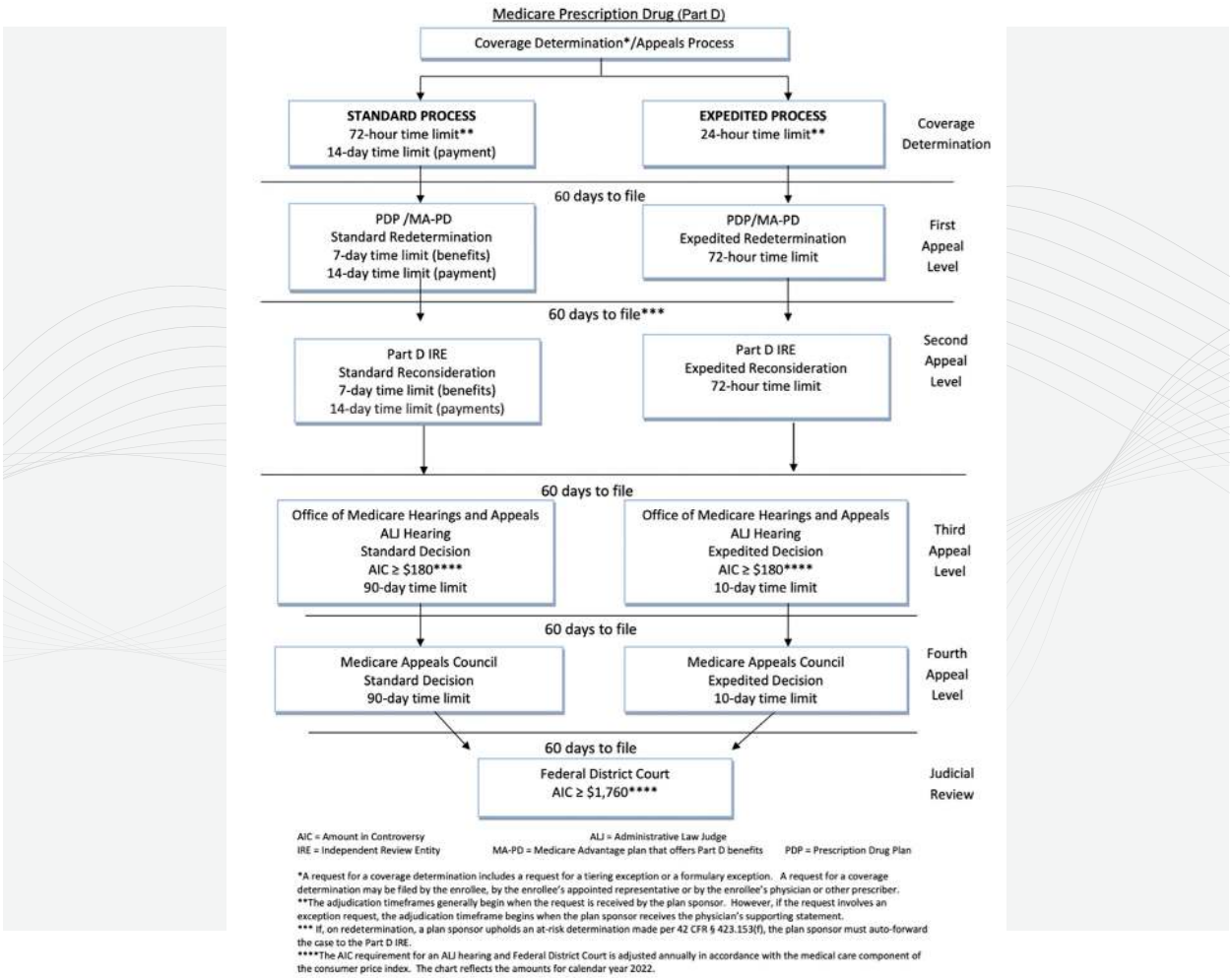
LEVEL 2: Review by an Independent Review Entity (IRE) [253]

LEVEL 3: Decision by the Office of Medicare Hearings and Appeals (OMHA) [254]

LEVEL 4: Review by the Medicare Appeals Council (Appeals Council) [255]

LEVEL 5: Judicial review by a federal district court [256]

THE FOLLOWING CHART GIVES AN OVERVIEW: [257]



Understanding the Enrollment Periods: [258]

1. INITIAL ENROLLMENT PERIOD (IEP)

The initial enrollment period is when you may first enroll in Part A, Part B, Part C, and Part D.

3 MONTHS BEFORE BIRTHDAY + BIRTH MONTH + THREE MONTHS = 7 MONTHS

Coverage takes effect first day of the month following enrollment.

2. SPECIAL ENROLLMENT PERIOD (SEP) [259]

A special enrollment period gives individuals a chance to enroll in a plan without penalty. Possible qualifying scenarios include moving to a new region, employer-sponsored insurance ends, moving back to the USA after living abroad, moving in or out of a nursing home or long-term care facility, and more.

The date coverage begins after SEP enrollment depends on the type of SEP and the life event that led to it.

3. GENERAL ENROLLMENT PERIOD (GEP)

The general enrollment period is when you can sign up for Part A and/or Part B. Penalties may apply.

JANUARY 1 – MARCH 31 OF EACH YEAR

Coverage takes effect July 1.

4. MEDIGAP OPEN ENROLLMENT PERIOD (MOEP)

The Medigap open enrollment period is when you may sign up for a supplemental (Medigap) policy —without underwriting based on medical conditions

EACH YEAR FROM THE FIRST DAY OF THE MONTH THAT YOU TURN 65 OR 6 MONTHS FROM WHEN YOU ENROLL IN PART B AFTER YOUR EMPLOYER HEALTH INSURANCE ENDS. [260]

NOTE: Some insurers allow only 180 days, instead of six calendar months.

Coverage typically starts the first of the month after you apply, but you can decide when you want it to start.

5. ANNUAL ENROLLMENT PERIOD (AEP)

The annual enrollment period is when you can switch from Original Medicare to Medicare Advantage (or vice versa), switch Medicare Advantage plans with drug coverage to one without drug coverage (or vice versa), enroll in or drop Part D, switch to a new Medicare Advantage plan or new Health Plan carrier.

OCTOBER 15 – DECEMBER 7 OF EACH YEAR

Coverage takes effect January 1.

6. MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MAOEP)

When anyone enrolled in a Medicare Advantage plan can make a one-time change to another Medicare Advantage plan (with or without Medicare Part D prescription coverage) or elect to change to Original Medicare and be eligible for a Medicare Part D plan.

JANUARY 1 – MARCH 31 OF EACH YEAR

Coverage takes effect the next month.

Avoid Premium Payment Delays

If you do not pay your Medicare premiums on time, you could lose your coverage, However, **you will not be dropped without a warning**.

Although you can choose not to enroll in any part of Medicare, Medicare Part A (hospitalization) is free to most Americans. For those who get free Part A, if you want more coverage (or want to guarantee that you will not be hit with late enrollment penalties in the future), you will typically have three ongoing premium payments starting at age 65, regardless of whether you choose Original Medicare or Medicare Advantage:

ORIGINAL MEDICARE	MEDICARE ADVANTAGE (MA)
Part B (medical)	**Part B**
Part D (prescriptions)	**Part D (if not included in MA)**
Medigap (deductibles, copays, coinsurance)	**Part C (MA, if not zero-dollar premium)**

If you're receiving Social Security, your Part B premiums will automatically be deducted from your Social Security checks. Thus, as Part B premiums rise, your Social Security checks will shrink. However, whether you think this is a good idea or not, it means you will never need to worry about missing a payment and losing coverage for lack of payment. MedicareResources.org says you can also choose to have your Part D premium, and your Medicare Advantage premium, deducted from your Social Security check.[261]

If you pay your premiums manually, **keep track of your payment deadlines** or you could lose coverage and face a lifetime of fewer choices and higher costs due to penalties. Medicare Resources.org suggests, "automating the process via recurring debits or credit card payments is the best way to avoid accidentally falling behind on Medicare bills and putting your coverage at risk of termination."[262] There are four payment options. Find them here: medicare.gov/basics/costs/pay-premiums

MedicareResources.org describes the bill, payment, and warning process:

> "Your Medicare Part B payments are due by the 25th of the month following the date of your initial bill. For example, if you get an initial bill on February 27, it will be due by March 25. If you don't pay by that date, you'll get a second bill from Medicare asking for that premium payment. That second bill will be due by the 25th of the following month – in this case, April 25.

> "If your second bill remains unpaid by its due date, you'll receive a delinquency notice from Medicare. At that point, you'll need to send in the total overdue amount by the 25th of the following month to avoid losing coverage. In our example, that would put you at May 25.
>
> "**All told, you'll have a three-month period to pay an initial Medicare Part B bill**. If you don't, you'll receive a termination notice informing you that you no longer have coverage. [emphasis added]
>
> "Now if you manage to pay what you owe in premiums within 30 days of that termination notice, you'll get to continue receiving coverage under Part B. If you don't do that, your coverage will be discontinued. At that point, you'll need to sign up for Part B once again during the general Medicare enrollment period that runs from January 1 to March 31 every year."[263]

Missing Part C or Part D payments can also lead to loss of coverage, but the process depends on your specific plan. Grace periods must be at least two months, and no plan can drop you without a warning notice. However, if you fail to pay the bill within the grace period you can be disenrolled from your plan.

If you're disenrolled from your Part D plan, you may be able to restore it under **Medicare's "Good Cause" policy,** such as for a prolonged illness. However, if you go without Part D coverage for 63 days or longer, you may be charged with a late enrollment penalty that will increase Part D premiums for the rest of your life.[264]

If you're disenrolled from a Medicare Advantage plan you'll be automatically enrolled in Original Medicare and you cannot re-enroll in Medicare Advantage until the Annual Enrollment Period, which is October 15 to December 7 each year. **NOTE:** if you choose to have your Medicare Advantage premiums deducted from your Social Security check, and that doesn't happen – resulting in a delinquency notice – your plan must work with Medicare to resolve the issue, and you cannot be disenrolled while you wait for the problem to be resolved.[265]

BOTTOM LINE: PAY YOUR PREMIUMS ON TIME, INCLUDING FOR MEDIGAP INSURANCE, TO AVOID BEING DISENROLLED, LOSING COVERAGE OPTIONS, AND GETTING HIT WITH LIFETIME PENALTIES.

Fraud Protection

More than 67 million people are enrolled in Medicare in 2024, nearly half of them — 33 million — in Medicare Advantage plans. This enormous federal government program, which paid out $839 billion in 2023 (14 percent of all federal spending) facilitates errors and invites fraud. To protect yourself against fraud, the ***Medicare & You*** handbook from the Centers for Medicare & Medicaid Services (CMS) advises the following:

A. PROTECT YOUR MEDICARE NUMBER: CMS advises protecting your card and not giving out your Medicare number except to doctors, pharmacists, other health care providers, your insurers, or trusted people working with Medicare.

B. HANG UP. If someone calls, claiming to be from Medicare, remember that Medicare doesn't call you to sell anything or ask for personal information.

C. RECORD KEEPING: CMS recommends keeping records of your doctor visits, tests, and procedures to check against your Medicare claims.

D. REVIEW STATEMENTS: Medicare advises that you check your Medicare Summary Notice (MSN) and claims from your Medicare health plan for errors.

E. REPORT SUSPICIONS: The ***Medicare & You*** handbook provides instructions on how to report suspected fraud, including calling 1-800-MEDICARE.

F. MEDICAL IDENTITY THEFT: Review the medical identity theft section of the ***Medicare & You*** handbook, including how to protect against it.

G. SENIOR MEDICARE PATROL PROGRAM: Check out this program, which educates and empowers seniors to prevent health care fraud.

H. SEND TIPS TO CMS: Although investigating fraud takes time, information shared by Medicare recipients helps protect Medicare and taxpayers.

I. BE AWARE OF SCAMS: The CMS ***Medicare & You*** handbook lists specific practices that might indicate fraud, such as offers of free medical equipment or pressure to accept medical services you don't need.

- To find out if a doctor or facility participates in Medicare, visit Medicare.gov/care-compare.
- To find out if a medical equipment supplier accepts Medicare assignment (payment), visit Medicare.gov/medical-equipment-suppliers.

J. ONLINE ACCOUNT SECURITY: CMS encourages each Medicare recipient to creat a secure online Medicare account to help detect potential fraud early.

YOU MAY ALSO SEEK LEGAL ADVICE: Contact an attorney specializing in the False Claims Act. The False Claims Act allows private citizens to file lawsuits on behalf of the government (called "qui tam" suits) against those who have defrauded the federal government. If successful, the private citizen may receive a portion of the government's recovery.[266]

Key Terms

The following is not an inclusive list of all the terms you may see when looking at Medicare options. Most definitions, unless sourced elsewhere in the endnotes (note the caveat listed in "IMPORTANT" below), are found in or derived from glossaries, including **Data.CMS.gov** (http://bit.ly/3NxhHoY) and:

- **Medicare.gov** - ***"Medicare & You 2024"***
  https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf
- **HealthCare.gov** - "Glossary"
  https://www.healthcare.gov/glossary/
- **Medicare.org** - "Common Medical Terms"
  https://www.medicare.org/articles/common-medicare-terms/

IMPORTANT: Many of the following key terms derive from official definitions but may include notes or emphasis from CCHF. Quoted definitions have not been altered except by use of brackets. Find the official definitions in the glossary links above. **NOTE:** Medicare.gov no longer maintains a glossary. All definitions from "(Medicare.gov)" are in the ***2024 Medicare & You*** Handbook. **Review official resources or contact your Medicare agent if you need more explanation about any word or term.**

3-DAY RULE: Requires the patient to have a medically-necessary, 3-consecutive-day inpatient hospital stay, which doesn't include the discharge day or pre-admission time in the emergency department (ED or outpatient observation. (CMS.gov)[267] If the patient does not immediately transfer from the hospital to the SNF, but qualified for SNF care coverage, the patient has 30 days to use this benefit.[268] (RAC Monitor)

ACCOUNTABLE CARE ORGANIZATION (ACO): A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients receive. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. (HealthCare.gov)

NOTE: ACOs, which participate in the government's "shared savings" program,[269] may be rewarded financially for reducing the cost of their patient's medical treatment. These "kickbacks" can provide a perverse incentive to prescribe cheaper medications, provide cheaper care or lower quality medical devices, and reduce access to care. On October 28, 2015, the federal government issued a rule waiving the application of the Federal anti-kickback statute and the civil monetary penalties law provision relating to beneficiary inducements to specified arrangements involving ACOs.[270] Thus, inducements are likely in full swing.

ANNUAL ELECTION PERIOD (AEP) [ANNUAL ENROLLMENT PERIOD]: During the AEP, Medicare Advantage-eligible individuals may enroll in or disenroll from an MA plan. The last enrollment request made, determined by the application date, will be the enrollment request that takes effect. AEP occurs from [October 15 through December 7] of every year. The AEP is also called the "Fall Open Enrollment" season in Medicare beneficiary publications and other tools. (Medicare.org)

ANNUAL NOTICE OF CHANGES (ANOC): If you're in a Medicare plan, your plan will send you a "Plan Annual Notice of Change" (ANOC) each fall. The ANOC includes any changes in coverage, costs, and more that will be effective in January.[271] (Medicare.gov)

ASSIGNMENT: An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance. (Medicare.gov)

BALANCE BILLING: When a provider bills you for the difference between the provider's charge and the amount allowed by Medicare. For example, if the provider's charge is $100 and the amount allowed by Medicare is $70, you would be charged for the remaining $30. Balanced billing by providers participating in Medicare is currently prohibited. (CMS.gov)

BENEFICIARY: A person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid. (Social Security Act)

BENEFIT PERIOD: The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or up to 100 days of skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. (Medicare.gov) According to Medicare Interactive, "Medicare covers up to 100 days of care in a skilled nursing facility (SNF) each benefit period."[272] Read SNF rules carefully. Check endnote.[273]

BROKER: A licensed advisor, also called an insurance agent, who represents multiple insurance companies and can help individuals evaluate plan options, along with helping you enroll into a plan. A broker may or may not offer all types of plans. Brokers usually collect a commission for selling you

an insurance company's plan. Some brokers only focus on helping individuals enroll for the first time. Others advise people who are already enrolled in Medicare. Some offer follow-up and support services. Others don't. (NCOA.org)

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS): The US federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. (Medicare.org)

COINSURANCE: A percentage of the cost you pay after you pay your deductible. In Part B, you generally pay 20% of the approved cost for each Medicare-covered service. (Medicare.gov and HealthCare.gov)

COORDINATION OF BENEFITS: the "primary payer" pays up to the limits of its coverage, then sends the rest of the balance to the "secondary payer." If the "secondary payer" doesn't cover the remaining balance, you may be responsible for the rest of the costs. If your group health plan or retiree coverage is the secondary payer, you may need to sign up for Medicare Part B before they'll pay. This order of payment is called "coordination of benefits." If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill, and then later recover any payments the primary payer should've made.[274] [275] (Medicare.gov)

CONDITIONAL PAYMENT: a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare if you get a settlement, judgment, award, or other payment later. You are responsible for making sure Medicare gets repaid from the settlement, judgment, award, or other payment.[276]

COPAYMENT: A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. (Healthcare.gov)

COST SHARING: The share of costs for services covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums. (HealthCare.gov)

CREDITABLE COVERAGE: Health coverage you have had in the past, such as group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or Medicaid, and this prior coverage was not interrupted by a significant break in coverage. The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by a new health plan. Creditable coverage may be proven by a certificate of creditable coverage or by other documents showing an individual had health coverage, such as a health insurance ID card. See also Certificate of Creditable Coverage. (Medicare.org)

CREDITABLE COVERAGE (MEDIGAP): Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy; see "Pre-Existing Conditions." (Medicare.org)

CREDITABLE PRESCRIPTION DRUG COVERAGE: Prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage. This could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, VA, or individual health insurance coverage. (Medicare.gov)

CRITICAL ACCESS HOSPITAL: A small facility located in a rural area more than 35 miles (or 15 miles if mountainous terrain or in areas with only secondary roads) from another hospital or critical access hospital. This facility provides 24/7 emergency care, has 25 or fewer inpatient beds, and maintains an average length of stay of 96 hours or less for acute care patients. (Medicare.gov; P.L. 105-33)

CUSTODIAL CARE: Non-skilled personal care to help with activities of daily living, such as bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care. (Medicare.org)

DEDUCTIBLE: The amount you must pay for medical treatment and other health care services or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay. (Medicare.gov)

DONUT HOLE: Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again. (HealthCare.gov). *The Inflation Reduction Act of 2022 ended the donut hole.*

DUALLY ELIGIBLE INDIVIDUALS: People who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals, fall into several eligibility categories. These individuals may either be enrolled first in Medicare and then qualify for Medicaid, or vice versa. Dually eligible individuals are enrolled in Medicare Part A (Hospital Insurance) and/or Part B (Supplemental Medical Insurance) and are also enrolled in full-benefit Medicaid and/or the Medicare Savings Programs (MSPs) administered by each individual state. MSPs are Medicaid eligibility groups that assist low-income Medicare beneficiaries with some or all of their Medicare Parts A and B expenses.[277] (CMS.gov)

DURABLE MEDICAL EQUIPMENT (DME): Certain medical equipment ordered by a doctor for use in the home; for example, walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services. (Medicare.org)

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC): A private company that contracts with Medicare to pay bills for durable medical equipment. (Medicare.org)

ELECTION: Your decision to join or leave Original Medicare or a Medicare+Choice [Medicare Advantage] plan. (Medicare.org)

END STAGE RENAL DISEASE (ESRD): ESRD is permanent kidney failure requiring dialysis or a kidney transplant. (Medicare.org)

ENROLLMENT PERIODS: see Understanding the Enrollment Periods (page 77)

EXCESS CHARGES: If you are in Original Medicare, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. (Medicare.org)

EXPEDITED ORGANIZATION DETERMINATION: A fast decision from the [Medicare Advantage] organization about whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized. (Medicare.org)

EXTRA HELP: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance. (Medicare.gov)

FEE-FOR-SERVICE: A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits [and treatment]. (HealthCare.gov)

FORMULARY: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list. (Medicare.gov)

GENERAL ENROLLMENT PERIOD (GEP): You can sign up for Medicare between January 1-March 31 each year. This is called the General Enrollment Period. Your coverage starts the month after you sign up. You might be required to pay a monthly late enrollment penalty if you don't qualify for a Special Enrollment Period.[278] (Medicare.gov)

GENERIC DRUG: A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs. (HealthCare.gov)

GUARANTEED ISSUE RIGHTS (ALSO CALLED "MEDIGAP PROTECTIONS"): In limited situations, health plans must permit you to buy certain Medigap policies, cover your pre-existing conditions, and cannot charge you more because of health problems. (Medicare.gov)

GUARANTEED RENEWABLE: Generally, guaranteed renewable is a requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage. (HealthCare.gov) In Medicare, any new Medigap policy issued since 1992 is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you stay enrolled and pay the premiums. (Medicare.gov)

HEALTH MAINTENANCE ORGANIZATION (HMO) (MEDICARE): A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care *[with limitations - see definitions of Health Maintenance Organization (HMO) Plan and Medicare Part C below]*. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to a specific network of doctors, specialists, or hospitals on the plan's list except in an emergency. In most cases, you will need to choose a primary care doctor, who you will need to get a referral from before seeing a specialist. (Medicare.org)

HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN: In most HMO Plans, you can only go to doctors, other health care providers, or hospitals on the plan's list except in an emergency. You may also be required to get a referral from your primary care doctor. In HMO Plans, you are not allowed to get your health care from any doctor, other health care provider, or hospital *[if you want the cost covered]*. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option. (Medicare.org)

HOME HEALTH CARE: Limited, part-time, or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services. (Medicare.org)

HOSPICE CARE: A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well. Hospice care is covered under Medicare Part A (Hospital Insurance). (Medicare.org) [**NOTE:** The Office of Inspector General at the U.S. Department of Health and Human Services (HHS) in a March 28, 2023 report titled "Hospice," noted four "Problem Areas in the Medicare Hospice Care Benefit," including:

- **Most have at least one deficiency in their quality of care, and hundreds are poor performers.**
- **Creates incentives for hospices to minimize services and seek patients with uncomplicated needs.**

HOSPITAL-ISSUED NOTICE OF NON-COVERAGE (HINN): Used for Original Medicare beneficiaries or Medicare Advantage enrollees, hospitals provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the items or services the beneficiary is receiving, or is about to receive, are not covered because it is:

- **Not medically necessary;**
- **Not delivered in the most appropriate setting; or**
- **Custodial in nature** [279] (CMS.gov)

INITIAL ENROLLMENT PERIOD (IEP): Generally, when you turn 65 years old. This period lasts for 7 months, starting the 3 months before you turn 65, and ending 3 months after the month you turn 65.[280] (Medicare.gov)

INPATIENT: "An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that her or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and actually use a hospital bed overnight." (CMS.gov)

INPATIENT CARE: Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility. (HealthCare.gov) See also definition of "Inpatient" (above) and "Inpatient Hospital Services" from the CMS Medicare Benefit Policy Manual.[281]

INSURANCE AGENT: also known as a broker, this individual is a state-licensed insurance agent who can help you navigate the specific plan options in your area and help you decide which plan(s) are best for you. See also definition of "Broker" (above).

INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA): The income-related monthly adjustment amount (IRMAA) sliding scale is a set of statutory percentage-based tables used to adjust premiums for Medicare Part B and Part D prescription drug coverage. The higher the beneficiary's range of modified adjusted gross income (***MAGI - see definition below***), the higher the IRMAA.[282] (SSA.gov)
NOTE: In 2024, the IRMMA starts at individual income of $103,000 ($206,000 joint) and goes up through five tiers of income levels.

INPATIENT REHABILITATION FACILITY: A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients. (Medicare.gov)

LIFETIME RESERVE DAYS: In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. ***You have a total of 60 reserve days that can be used during your lifetime***. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance. (Medicare.gov) A person is not required to apply all lifetime reserve days to the same hospital stay. In addition, if an individual does not want to use their lifetime reserve day, "they should indicate that wish in writing to their hospital," states MedicalNewsToday.[283]

LIMITING CHARGE: In Original Medicare, this is the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. These providers are called "non-participating providers." They see Medicare patients, accept Medicare reimbursement as *partial payment*, and can charge an additional amount called the limiting charge. The limiting charge is a maximum of 15 percent over Medicare's approved amount. The limiting charge only applies to certain services, such as payments to non-participating providers, and does not apply to supplies or equipment. (Medicare.org and MedicareResources.org)

LONG-TERM CARE: Also called "custodial care" or "long-term services and support," long-term care includes medical and non-medical care for people who have a chronic illness or disability. (Medicare.gov) Services include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Medicare and most health insurance plans don't pay for long-term care. (HealthCare.gov)

LONG-TERM CARE HOSPITAL: Long-term care hospitals typically provide care to patients with more than one serious medical condition. The patients may improve with time and care, and eventually return home. Long term care hospitals may offer services like respiratory therapy, head trauma treatment and pain management. (Medicare.gov) LTC hospitals include acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. (Medicare.gov)

MAXIMUM OUT-OF-POCKET (MOOP)]: The maximum dollar amount, including deductibles, co-payments, and coinsurance that you may be required to pay in any calendar year toward the cost of covered medical care. "Plans have a yearly limit on what you pay out of pocket for services Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for Part A and Part B services **the plan covers** for the rest of the year. (Medicare.org) The federal government sets the standard Medicare Advantage MOOP each year. **NOTE:** The words "the plan covers" are important. Medicare Advantage plans too often deny coverage for medically-necessary, Medicare-approved services. See page 69. If you need medical care that has been denied, and cannot appeal the decision in time, or lose the appeal, you will have to pay out of pocket for it. That out-of-pocket payment will not count toward your MOOP.

MEDICAID: A joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. Medicaid offers services not normally covered by Medicare, like nursing home care and personal care services. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. (Medicare.gov)

MEDICAL UNDERWRITING: The process that an insurance company uses to decide, based on your medical history, whether or not to accept your application for health insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance. (Medicare.org)

MEDICALLY NECESSARY: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. (Medicare.gov) **NOTE:** Standards of care in medicine vary and often depend on the developor's position. The ***AMA Journal of Ethics*** reports, "federal agencies have played a critical role in the development of medical standards of care." The author notes, "medical standards now come from a multitude of sources" and questions whether standards are "marshalling the best information to guide clinical practice, She asks, "Should standards from 'within' the profession agree with standards from 'without'—from the business office, for example—***particularly when external standards have cost containment as the end being pursued rather than a patient's individual interest?"*** [Emphasis added.] ("The Origins and Promise of Medical Standards Of Care," Eleanor D. Kinney, JD, MPH, ***AMA Journal of Ethics***, December 2004)

MEDICARE: Medicare is a health insurance program for people age 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD). Medicare consists of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D). This guide compares and contrasts Medicare Advantage with Original Medicare, also known as Medicare fee-for service.

Medicare is a defined benefit program. It only covers certain devices, supplies, drugs, and biologicals that have been determined to fall within a specific benefit category, are not excluded from Medicare coverage by law, and, in most cases, are reasonable and necessary as described in section 1862(a)(1)(A) of the Act. (CMS.gov)

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MAOEP): If you're already enrolled in a Medicare Advantage Plan, this period runs from January 1–March 31. If you're new to Medicare and enroll in a Medicare Advantage Plan, this period runs from the month you're eligible to enroll in Part A and Part B, until the last day of the 3rd month you're eligible. (You can make only one change during this period. Changes will take effect the first day of the month after the plan gets your request.) During Medicare Advantage open enrollment, you can:

- Switch to another Medicare Advantage Plan (with or without drug coverage).
- Drop your Medicare Advantage Plan and go back to Original Medicare. If you do this, you'll be able to enroll in a Medicare drug plan.[284] (Medicare.gov)

MEDICARE ADVANTAGE PLAN (PART C): A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in a Medicare Advantage plan. Medicare Advantage Plans include:

- **Health Maintenance Organizations**
- **Preferred Provider Organizations**
- **Private Fee-for-Service Plans**
- **Special Needs Plans**
- **Medicare Medical Savings Account (MSA) Plans**

If you're enrolled in a Medicare Advantage Plan:

- **Most Medicare services are covered through the plan**
- **Most Medicare services are not paid for by Original Medicare**
- **Most Medicare Advantage Plans offer prescription drug coverage** (Medicare.gov)

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLAN: A Medicare Advantage plan that offers Medicare Prescription Drug coverage and Part A and Part B benefits in one plan. (Medicare.org)

MEDICARE-APPROVED AMOUNT: Generally referring to Part B, this is the payment amount that Original Medicare sets for a covered service or item. Thus, this is how much Medicare will pay your doctor or provider for your medical services. When your doctor or provider accepts assignment, Medicare pays its share of the Medicare-approved amount and and you pay your share. (Medicare.gov)

MEDICARE MEDICAL SAVINGS ACCOUNT (MSA): A unique type of Medicare Advantage (Part C) plan that combines a high-deductible health plan with a medical savings account. People on Medicaid and those with military-sponsored benefits are not eligible. The health plan deposits money provided by Medicare into an interest-bearing savings account at the start of the year. These tax-free dollars can be spent on qualifying Medicare Part A and Part B services, plus medications and dental, vision, and hearing services. You can receive fee-for-service medical care anywhere in the U.S. You're not restricted to a Medicare Advantage network of providers and hospitals. If you spend it all, you must pay out of pocket for all of your care until you meet the plan's deductible. If you don't spend all the money in your account, it rolls over into the next year. (ncoa.org, May 20, 2024) **NOTE:** In 2024, the only Medicare MSA Plan available is in Wisconsin. (Medicare.org)

MEDICARE PART A: Medicare Part A is "Hospital Insurance." It helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care for qualified recipients. (Medicare.org)

MEDICARE PART B: Medicare Part B is "Medical Insurance." It helps cover doctors' services, outpatient care, home health care, and some preventive services for qualifed recipients. (Medicare.org)

MEDICARE PART C (MEDICARE ADVANTAGE PLANS): A health coverage option offered by private insurance companies approved by and under contract with Medicare. It includes Part A, Part B, and usually other coverage, such as prescription drugs. (Medicare.org) **"Each Medicare Advantage Plan must provide all Part A and Part B services covered by Original Medicare but they can do so with different rules, costs, and restrictions that can affect how and when you receive care."** ("The Parts of Medicare (A, B, C, D)," MedicareInteractive.org, accessed 10/19/24)

MEDICARE PART D (PRESCRIPTION DRUG PLAN): Medicare Part D is prescription drug coverage offered by private insurance companies approved by and under contract with Medicare. It helps cover the cost of prescription drugs, and may help lower your prescription drug costs and help protect against higher costs in the future. There are 2 types of Part D plans: Integrated Medicare Advantage-Part D Plans and Standalone Prescription Drug Plans (Part D). (Medicare.org)

MEDICARE PLAN: Any way other than Original Medicare that you can get your Medicare health or drug coverage. This term includes all Medicare health plans and Medicare drug plans. (Medicare.gov)

MEDICARE SAVINGS PROGRAM (MSP): Sponsored by state *Medicaid* agencies, these programs help you pay for your Medicare out-of-pocket costs including premiums, deductibles, coinsurance, and/or copayments. They are also called "Medicare Buy-In Programs" or "Medicare Premium Payment Programs." You must be enrolled in at least Medicare Part A. If you're in an MSP, you automatically qualify for the Extra Help program (see above). Four MSP programs exist: https://www.ncoa.org/article/medicare-savings-programs-vs-medicare-medical-savings-accounts-are-they-the-same/

MEDICARE SELECT: A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits. (Medicare.org)

MEDICARE SUMMARY NOTICE (MSN): A notice you get after the doctor or provider files a claim for Part A and Part B services in Original Medicare. It explains what service or item the provider billed for, the amount the provider charged, the Medicare-approved amount (see definition above), how much Medicare paid the provider, and what you must pay. (Medicare.org)

MEDIGAP: Medicare Supplement Insurance sold by private insurance companies to fill payment "gaps" in Original Medicare coverage.[285] (Medicare.gov)

MEDIGAP OPEN ENROLLMENT PERIOD (MOEP): A one-time, 6-month [technically 180-day] period to buy Medigap, starting the first month you have Part B if you're 65 or older. During this time, you:

- Can enroll in any Medigap policy.
- Will generally get better prices and more choices among policies.
- You can buy any Medigap policy sold in your state. An insurance company can't use medical under writing to decide whether to accept your application - they can't deny you coverage due to pre-existing health problems.
- Can avoid or shorten waiting periods for a pre-existing condition if you buy a Medigap policy to replace creditable coverage.

After this period, Medigap policies may be unavailable, or cost more. Your Medigap Open Enrollment Period happens only once. It never repeats. **NOTE:** Some state laws permit the purchase of Medigap by individuals under the age of 65, sometimes at higher cost. *("Medigap Eligibility Rules for Americans Under Age 65 Vary by State," medicareresources.org, 9/23/2024)* Generally, Medigap policies take effect the first of the month after you apply, but you can decide when you want it to start.[286] (Medicare.gov)

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS): MIPS ties physicians' Medicare payments to their individual, group practice, or alternative payment model (APM) score on reported and applicable: (1) quality measures; (2) cost measures; (3) health IT use, including data reporting; and (4) practice improvement activities.[287] **NOTE:** the definition of these four items is determined by the federal government, forcing physicians to comply with government directives to receive full payment for care.

MODIFIED ADJUSTED GROSS INCOME: For the purpose of determining whether an individual must make IRMAA payments for Medicare Part B and Part D premiums, the MAGI is the sum of a person's adjusted gross income plus items such as, but not limited to, untaxed foreign income, non-taxable Social Security benefits, tax-exempt interest, and IRA contributions (HealthCare.gov and IRS.com).

NON-FORMULARY DRUGS: Brand name or generic prescription drugs not included on a health plan's list of approved prescription drugs. (Medicare.org)

NETWORK: "A group of doctors, hospitals, and medical facilities that contract with a plan to provide services." For example, "An HMO Plan is a type of Medicare Advantage Plan that generally provides health care coverage exclusively from doctors, other health care providers, or hospitals in the plan's network . . . If you get care outside the plan's network without authorization, you may have to pay the full cost.." (Medicare.gov)

OBSERVATION STATUS: A designation within the "outpatient" category used by hospitals to bill Medicare. **NOTE:** "Since March 8, 2017, hospitals have been required to give patients the Medicare Outpatient Observation Notice (MOON) within 36 hours if the patients are receiving observation services as an outpatient for 24 hours. Hospitals must also orally explain observation status and its financial consequences for patients. The MOON cannot be appealed to Medicare."[288] (Center for Medicare Advocacy, MedicareAdvocacy.org)

ORIGINAL MEDICARE: "Original Medicare is our country's federal health insurance program available for people over 65, people with disabilities including ALS, and end-stage kidney disease. It includes Part A (hospital insurance) and Part B (medical insurance) and works on a fee-for-service basis. You can receive services from any provider or facility that accepts Medicare. You have to pay for services that Medicare doesn't cover and monthly premiums, annual deductibles, coinsurance and copays." ("Outpatient Observation Status, Medicare Plans Patient Resource Center, n.d., MedicarePlans.com)

OUT-OF-NETWORK PROVIDER: A doctor, dentist, hospital or other practitioner who is not contracted with that particular Medicare Advantage health plan. (Medicare.org)

OUT-OF-POCKET COSTS: Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered. (HealthCare.gov) An out-of-pocket cost is the amount you will pay beyond what Medicare covers. Medicare Parts A and B have no maximum out-of-pocket (MOOP). Only Medicare Advantage and some Medigap plans have a MOOP. *See definition for Maximum Out-of Pocket.*

OUTPATIENT: A patient who has not been formally admitted into the hospital as an inpatient. Most outpatient care is covered under Medicare Part B. (MedicareInteractive.org)

OUTPATIENT HOSPITAL CARE: Medical or surgical care furnished to you by a hospital if you have not been admitted as an inpatient but are instead registered in hospital records as an outpatient. **NOTE:** If a doctor orders you to be placed under observation, it will likely be considered outpatient care, even if you stay in the hospital overnight. (Medicare.org) *For financial impact, see Observation Status above.*

OUTPATIENT MEDICAL SERVICES AND SUPPLIES: Certain medical equipment that is ordered by a doctor for use in the patient's home. Examples are walkers, wheelchairs or hospital beds. Both Medicare Part B and Part A pay for durable medical equipment for home health services. (Medicare.org)

PRE-CLAIM REVIEW: "A process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted. **A pre-claim review is different than a prior authorization** due to the timing of the review and when services may begin. For prior authorization, a request must be submitted prior to serv ices beginning and providers should wait until they have a decision before they begin providing services. With a pre-claim review, services have already begun and the request is submitted after all of the initial assessments and intake procedures are completed and services have begun. The pre-claim review occurs after services start but prior to the final claim being submitted. . . . Medicare Administrator Contractors (MACs) will make these decisions using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements and other CMS policies." (CMS.gov).

PRE-EXISTING CONDITION: A health problem you had before the date that a new health insurance policy starts. (Medicare.org)

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN: A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for covered services at an additional cost. Referrals are not required for you to visit a specialist. (Medicare.org)

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS: A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. In a PPO Plan, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You pay more if you use doctors, hospitals, and providers outside of the network. In most cases, PPO Plans allow you to get health care services from any doctor, other health care provider, or hospital. PPO Plans have network doctors, other health care providers, and hospitals. Each plan gives you flexibility to go to doctors, specialists, or hospitals that aren't on the plan's list, but it will usually cost more. (Medicare.org)

PREMIUM: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. (Medicare.gov)

PREVENTIVE SERVICES: Services to prevent illness or detect illness at an early stage, when treatment is likely to work best (e.g., Pap tests, flu shots, and mammograms). (Medicare.gov)

PRIMARY CARE DOCTOR (PCP): The doctor you go to first for most health problems. The PCP may discuss your case with other doctors and health care providers and refer you to them. (Medicare.gov)

PRIOR AUTHORIZATION (PA): The requirement that your doctor, hospital or other provider seek approval from a health plan before you get a service or fill a prescription to confirm that the service or prescription will be paid for by your plan. (HealthCare.gov) The provider or supplier submits the prior authorization request with all supporting medical documentation and receives the decision before services are rendered. The Medicare Administrator Contractor (MAC) reviews the PA request and sends the provider or supplier its decision to approve or deny the requested authorization. (CMS.gov)

PRIVATE FEE-FOR-SERVICE PLAN (PFFS): A type of Medicare Advantage Plan that permits you to go to any Medicare-approved doctor or hospital that accepts the plan's payment. The health plan "decides how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care." "Non-network doctors and other providers can choose to accept a PFFS plan patient on a service-by-service, patient-by patient basis. . . . If you're in a PFFS plan, confirm that your provider accepts your plan on every visit." (Medicare.org and eHealthInsurance.com)

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE): PACE combines medical, social, and long-term care services for frail individuals to help them stay independent and living in their community as long as possible, while getting the high-quality care they need. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must be 55 years old or older, live in the service area of the PACE program, be certified as eligible for nursing home care by the appropriate state agency, and be able to live safely in the community. (Medicare.org)

PROVIDER: A facility, supplier, physician, or or other individual or organization that has an agreement with the Centers for Medicare & Medicaid Services to provide health care services and supplies to Medicare beneficiaries. Examples include hospitals, clinics, skilled nursing facilities, home health agencies, hospice, radialogy centers, independent clinical laboratories, and rehabilitation facilities. Other examples: audiologists, nurse anesthetists, clinical psychologists, clinical social workers, dieticians, mental health counselors, nurse practitioners, physical therapists. (CMS.gov and WestLaw.com)

QUALIFIED MEDICARE BENEFICIARY (QMB): One of four state-run programs that help people who cannot afford their Medicare costs. Of the four programs, QMB is the one that offers the most assistance. A person who is enrolled in QMB is also enrolled in Medicaid. The other three state-run programs are Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI,) and Qualified Disabled and Working Individuals (QDWI). The QMB program does not allow drugstores to charge a person more than $3.90 for a prescription medication covered under Medicare Part D.[289]

QUALITY CARE: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[290]

COMMENT: "There is no common understanding of the term 'quality of care', and there is disagreement about what it encompasses." (NIH, 2019: https://bit.ly/3NBHHiI). In addition, "current professional knowledge" may be out of date or insufficient. Doctors need the freedom to use their clinical expertise and creativity to develop treatments that are customized to patients, not current to literature. Yet, doctors are paid for complying with a **standardized federal 'quality rubric'** rather than customizing care. *(See definition for Merit-Based Incentive Payment System)*. The federal Agency for Healthcare Research and Quality sees "underuse, overuse, misuse, and variation in use of health care services" as quality problems.[291] It says quality care is "safe, effective, patient-centered, timely, efficient, and equitable."[292] How does the federal government define these terms? **Would patients and doctors agree?**

QUALITY IMPROVEMENT: The framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, health care systems, and organizations.[293]

QUALITY IMPROVEMENT ORGANIZATION: Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service Plans, and ambulatory surgical centers. These doctors also review fast-track termination decisions in comprehensive outpatient rehabilitation facilities, skilled nursing facilities, and home health and hospice settings for people in Medicare health plans. (Medicare.org)

RECOVERY AUDIT CONTRACTOR (RAC): To reduce improper Medicare payments, the RACs conduct both complex and automated post-payment reviews, looking back up to three years from the date the claim was paid. Automated reviews occur at the system level (no medical record required) while complex reviews require a qualified individual to review the patient's medical record.

RECOVERY AUDIT PROGRAM: The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.[294] [**NOTE:** CMS reported an estimated $31.2 billion improper payments for Original Medicare, $16.6 billion for Medicare Advantage, and $3.4 billion for Medicare Part D in 2023.[295]]

REFERRAL: A written order from your primary care doctor directing you to visit a specialist or get certain medical services. Without a referral, your Medicare Advantage health plan may not choose to pay for services from a specialist. (Medicare.gov)

REGIONAL HOME HEALTH INTERMEDIARY (RHHI): A private company that contracts with Medicare to pay home health and hospice bills under Original Medicare and check on the quality of home health care. (Medicare.org)

REHABILITATION: Rehabilitation services are ordered by your doctor to help you recover from an illness or injury. These services are provided by nurses, and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed. (Medicare.org)

RETIREE DRUG SUBSIDY PROGRAM: The Retiree Drug Subsidy (RDS) Program was enacted in December 2003. It is "one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obntaining more generous drug coverage." Employers are reimbursed for a portion of their retiree's prescription drug costs (CMS.gov)

RISK ADJUSTMENT: A way to calculate capitated per member per month (PMPM) Medicare payments to providers and health plans using **risk scores** based on a patient's health, their likely use of medical services, and the costs of those services. In June 2024, a ***Wall Street Journal*** analysis found plans had added diagnoses to enrollees through chart reviews and at-home visits, making them look sicker, and resulting in $50 billion in Medicare overpayments. Some had diagnoses in charts for which they were never treated. (FierceHealthcare, 7/30/2023: https://bit.ly/3UfySiw) In 2023, HealthSun Health Plans was indicted by the DOJ and repaid $53 million. (Health Law Advisor, 11/2/2023: https://bit.ly/3Yw0oLh)

SECOND OPINION: A "second opinion" refers to an additional doctor giving his or her view about what medical or mental health condition you have and how it should be treated. (Medicare.org)

SECOND SURGICAL OPINION: In some cases, Medicare Part B (Medical Insurance) covers a second opinion for medically necessary, non-emergency surgery. Medicare also covers a third surgical opinion if the first and second opinions are different.[296] (Medicare.gov)

SECONDARY PAYER: An insurance policy, plan or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation. (Medicare.org) *See definition for Coordination of Benefits.*

SERVICE AREA: The service area is the geographic area where a Medicare Advantage Plan or Part D plan provides medical services to its members. In many plans, the service area is where your network of providers is located. An area you must live in for the plan to accept you as a member. It's also generally the area where you can get routine (non-emergency) services through the plan's network. Plans can, and in some cases must, disenroll you if you move outside their service area. Contact your insurance agent if you plan to move. (MedicareInteractive.org and Medicare.gov)

SHARED SAVINGS PROGRAM: Offers providers and suppliers (e.g., physicians, hospitals) an opportunity to create an Accountable Care Organization (ACO). See definition on page 83. An ACO agrees to be held accountable for the quality, cost, and experience of care of an **assigned population** of Original-Medicare (fee-for-service) recipients. The program [created by the Affordable Care Act] has different participation options (tracks) allowing ACOs to choose level of risks and rewards.[297] (CMS.gov)

SIGNIFICANT BREAK IN COVERAGE: Generally, a significant break in coverage is a period of 63 consecutive days during which an individual has no creditable coverage. In some states, the period is longer if the individual's coverage is provided through an insurance policy or HMO. Days in a waiting period during which you had no other health coverage cannot be counted toward determining a significant break in coverage. (Medicare.org)

SKILLED CARE: A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. (Medicare.org)

SKILLED NURSING CARE: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse). (Medicare.org)

SKILLED NURSING FACILITY (SNF): Places for people to live temporarily while they're getting rehabilitation and medical treatments after hospitalization for an illness or injury. Medicare Part A covers SNF care for a limited time, under certain conditions. A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services. (Medicare.gov) Skilled care is often given in a nursing home, but Medicare Part A doesn't cover long-term or custodial care in a nursing home. Part A will generally cover your drug costs if you're getting Medicare-covered skilled nursing care in a SNF. (Medicare.gov)

SKILLED NURSING FACILITY (SNF) CARE: Skilled nursing care and therapy services provided on a daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a physical therapist or a registered nurse. (Medicare.gov)

SPECIAL ELECTION PERIODS (SEPS): "An individual may at any time (that is, not limited to the annual coordinated election period) discontinue the election of an MA [Medicare Advantage] plan offered by an MA organization and change his or her election from an MA plan to original Medicare or to a different MA plan" under **27 circumstances** defined in the Code of Federal Regulations (CFR 42, Part 422.62, Subpart B - https://bit.ly/4fdQELd). In addition, the CFR states in a **"Special election period for individual age 65,"** a person who elects an MA plan during the initial enrollment period "may discontinue the election of that plan and elect coverage under original Medicare ***at any time*** during the 12-month period that begins on the effective date of enrollment in the MA plan." [Emphasis added.] **NOTE:** The Special Election Period is different from the Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD (SEP): A set period of time that you can make changes to your Medicare Advantage and Medicare drug coverage when certain events happen in your like, like if you move or you lose other coverage. The types of changes you can make and the timing depend on your life event. For help making enrollment changes, call 1-800-MEDICARE. (Medicare.gov)

SPECIAL NEEDS PLAN (SNP): Provides more focused health care for specific groups of people, such as those who are enrolled in both Medicare and Medicaid, reside in a nursing home, or have certain chronic conditions. The SNP will provide a primary physician or care coordinator to manage your care. Services are provided within the plan's network. Prescription drug coverage is included. (Medicare.org)

SPECIFIED DISEASE INSURANCE: Pays benefits for only a single disease, such as cancer, or for a group of diseases. It does not fill gaps in your Medicare coverage. (Medicare.org) **NOTE:** It could pay for covered services a Medicare Advantage plan claims are medically unnecessary and refuses to cover.

SPONSOR: An employer, a union, or some other entity that offers a health plan. (Medicare.org)

STAR RATINGS: CMS annually publishes the Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings that are said to be a measure of the quality of health and drug services received by consumers.[298] **A Medicare Advantage plan that earns at least 3.5 out of 5 stars qualifies for significant bonus payments** from CMS.[299] Per Humana, "Medicare uses information from member satisfaction surveys, health plans, and healthcare providers to determine Star ratings. The rating system uses more than 40 different quality measures...."[300] *(See definition for Quality)* After two courts ruled in 2024 that federal officials improperly modified the way it assesses quality and issues Star Ratings, CMS recalculated all Star Ratings for 2024. As a result, one plaintiff (SCAN Health Plan) will see an increase in Medicare payments of $250 million in 2025.[301] However, after CMS downgraded their star ratings, UnitedHealth Group sued, and Humana is appealing to CMS, due to the **likely loss of billions in bonus payments**. Humana may lose up to $3 billion in 2026. (Yahoo Finance, 10/2/24: https://yhoo.it/48gU1OX)

TIERS: A health plan's drug formulary is usually divided into tiers or levels of coverage based on the type or usage of the medication. Each tier will have a defined out-of-pocket cost that the patient must pay before receiving the drug. Many plans determine what the patient's costs will be by putting drugs into four tiers. These tiers are determined by: cost of the drug, cost of the drug and how it compares to other drugs for the same treatment, drug availability, clinical effectiveness, connection to standard of care, and other cost factors, including delivery and storage.[302] (PatientAdvocate.org)

TRICARE: A health care program for active-duty and retired uniformed services members and their families. (HealthCare.gov)

TRICARE FOR LIFE (TFL): Provides expanded medical coverage to Medicare-eligible uniformed services retirees aged 65 or older, their eligible family members and survivors, and certain former spouses. You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to get TFL benefits. (Medicare.org)

TWO-MIDNIGHT-RULE: Although case-by-case flexibility is allowed for the two-midnight rule, "for stays that are expected to be two midnights or longer . . . the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports the expectation that the patient would stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice."[303] (CMS.gov)

URGENTLY NEEDED CARE: Care that you receive for a sudden illness or injury that needs medical treatment right away but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan rather than Original Medicare. If you are out of your plan's service area and cannot wait until you return home, the health plan will pay for your urgently needed care. (Medicare.org and MedicareResources.org)

VETERANS ADMINISTRATION (VA) MEDICAL BENEFITS: Health coverage for veterans and individuals who have served in the U.S. military. You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may also join a Medicare Part D plan, but if you do, you cannot use both types of coverage for the same prescription. **For more information, call the VA at 1-800-827-1000, or visit www.va.gov. TTY users should call 1-800-829-4833.** (Medicare.org)

Frequently Asked Questions

DISCLAIMER: For every question below, our first answer is:
Always speak with your employer (if applicable), current insurance company or health care sharing organization, and a qualified Medicare insurance agent or health insurance broker to determine your eligibility and requirements as you near the age of 65.

I have employer sponsored health insurance. Should I enroll in Medicare when I turn 65?

Generally, no – if you have group health insurance available through your employer, and if there are 20 or more employees at your workplace, you are probably not required to enroll in Medicare Part A, Part B, or Part D, nor will you face penalties for not enrolling if you are employed and maintain health insurance coverage through your employer.[304]

ALERT: The 2025 change in Part D law under the Inflation Reduction Act of 2022 ($2,000 out-of-pocket maximum instead of $8,000 in 2024) could require you to get a standalone Part D plan if your employer's prescription drug plan is no longer determined to be "credible coverage."[305] Your employer will notify you if the employer's plan is credible coverage by October 15, 2024.[306] (**NOTE:** You never need to enroll in Plan C (Medicare Advantage) or Medicare Supplemental Insurance because they are optional.)

I have health insurance through my spouse's company. Should I enroll in Medicare when I turn 65?

Generally, no – if you are covered under your spouse's employer-sponsored group health insurance, you are probably not required to enroll in Medicare Part A, Part B, or Part D. As long as your spouse is employed and maintains health insurance coverage through his or her employer, you will probably not need to enroll.[307] (You never need to enroll in Plan C or Medigap because they are always optional.)

I have private health insurance that I personally purchased. Should I enroll in Medicare when I turn 65?

Generally, yes – most private health insurance plans do not fall under the "group health plan coverage" exclusion to the requirement to enroll in Medicare.[308] Failing to enroll during your initial enrollment period (IEP) may result in temporary and permanent financial penalties if you choose to enroll later.

I'm self-employed and have private health insurance. Should I enroll in Medicare when I turn 65?

Generally, yes – most private health insurance plans do not fall under the "group health plan coverage" exclusion to the requirement to enroll in Medicare.[309] Failing to enroll during your initial enrollment period may result in temporary and permanent financial penalties if you choose to enroll later.

I have a Health Care Sharing Ministry (HCSM). Should I enroll in Medicare when I turn 65?

It depends on your HCSM—Samaritan Ministries does not require you to enroll in Medicare—and your personal situation *(see page 57)*. Failure to enroll during your initial enrollment period may result in temporary and permanent financial penalties if you choose to enroll at a later time.

I have COBRA health insurance coverage. Should I enroll in Medicare when I turn 65?

Generally, yes. Medicare recommends that you sign up for Medicare when you turn 65 to avoid gaps in coverage and a monthly Part B late enrollment penalty. Since employers have the option of cancelling COBRA when Medicare entitlement begins, "once you enroll, your COBRA coverage will end." [310]

According to Medicare.gov, "If you have COBRA and you're eligible for Medicare but not enrolled, COBRA may only pay for a small portion of the health care services you get, and you may have to pay most of the costs yourself." Furthermore, "You have up to 8 months after you stop working (or lose your health insurance, if that happens first) to sign up for Part B without a penalty, whether or not you choose COBRA."[311]

I have TRICARE. Should I enroll in Medicare when I turn 65?

Generally, yes – if you have TRICARE you are likely required to enroll in Medicare Part A, Part B, and Part D or you could face penalties for delayed enrollment. Medicare becomes the primary payer, and the person is automatically enrolled in TRICARE For Life.[312] **NOTE:** Avoid Medicare Advantage *(See page 60)*

I have a complaint. Where do I appeal or file a grievance?

If you cannot resolve a situation by speaking with your doctor, clinic, hospital, health care facility or pharmacy, always start by speaking to your Medicare agent. The federal government has created processes for appealing coverage decisions and filing grievances, but they can be long, involved, and complicated. *(See pages 69 and 76)*

For grievances related to Part C (Medicare Advantage) and Part D (prescription drugs), the document released in 2022 is 117 pages long.[313] To file a **grievance related to Part C or Part D**, go to https://appeals.lmi.org. To file a **grievance related to Part A or Part B** (Original Medicare): https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-Parts-AandB-Appeals.pdf.
For appeals: https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf. [314]

Who pays first? Medicare or my insurance?

Per Medicare: "It depends on which insurance is considered 'primary' and which is 'secondary.' The insurance that pays first (primary payer) pays up to the limits of its coverage. The insurance that pays second (secondary payer) only pays if there are costs the primary insurance didn't cover."

Here are a few specifics: Medicare and Medigap always pay *before Medicaid*. No-fault insurance, liability insurance, worker's compensation, and TRICARE pay *before Medicare*. If you have employer-sponsored coverage, retiree health coverage, or other coverage, other rules apply. See the federal handbook called, ***Medicare's Coordination of Benefits*** for details.[315] If you still have questions about who pays first, Medicare directs you to call the Benefits Coordination & Recovery Center at 1-855-798-2627 (TTY: 1-855-797-2627).[316] See also "Coordination of Benefits" in the KEY TERMS section *(page 85)*.

How do I find out what Medicare pays and what I owe?

You have a right to receive a full explanation of your bill. Ask the billing department of the practitioner or health care facility to give you the **Medicare Summary Notice (MSN).**

The MSN is "A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay."[317]

For acronyms and terms that you do not understand, contact the billing office, your Medicare agent, and if necessary, the Medicare administration for an explanation. To contact Medicare, call 1-800-MEDICARE (1-800-633-4227) TTY users can call 1-877-486-2048. Live chat with Medicare at Medicare.gov/talk-to-someone. Write Medicare at PO Box 1270, Lawrence, KS 66044.

Consider creating a **Medicare account** online to track your Medicare status. You can also use the account to pay your premiums online. Reviewing your online Medicare account can help you to verify the accuracy of the account against what you have paid in deductibles, copays, and coinsurance.

12 Questions to Ask Medicare Agents

1. How much in commissions do you receive for selling each of the following: Medicare Advantage, Medigap, and Part D?
2. Do Medigap commissions differ according to the policy I choose, and do you get commissions for each year that I'm on Medicare?
3. Share with me the history of premium increases for the available Medigap and Part D policies (and deductible increases for high-deductible policies).
4. Which of the available Medigap policies have been around for longer than five years and have an A-rating with AM Best?
5. Are you allowed to talk to me about extra benefits in Medigap policies? *(see Medicare Supplemental Insurance section)*
6. Are there any available policies that you are not offering me as an option, and if so, what are they and why?
7. To avoid penalties, what is the last day (**exact date**) that I can sign up through you for my Medigap and Part D policies?
8. What Medicare options will give me the most choices, best prices, and least restrictive access to care?
9. How available are you when I need help during the year, and will I be meeting with you each year to review my options?
10. How long do I have to change my mind about my initial choices?
11. Who do you send my enrollment data to? Corporations, government, others?

BONUS: Other questions YOU have: _____

My Medicare Checklist

6-12 MONTHS **BEFORE** TURNING 65

- ☐ **EXPLORE THIS HOW-TO GUIDE (AND OTHER RESOURCES) TO:**
  - ☐ Learn about Part A (Hospital)
  - ☐ Learn about Part B (Medical)
  - ☐ Evaluate Part C (Medicare Advantage)
  - ☐ Learn about Part D (Prescription Drugs)
  - ☐ Consider Medigap (Supplement)
  - ☐ Confirm eligibility with Social Security Administration by creating a "My Social Security" Account
  - ☐ Decide when you need to enroll to avoid unintended delays or penalties
  - ☐ **IMPORTANT:** begin discussions with a licensed Medicare agent

3-6 MONTHS **BEFORE** TURNING 65

- ☐ **IMPORTANT: CONFIRM DECISIONS WITH LICENSED MEDICARE AGENT**
  - ☐ Add all costs per month and per year for:
  - ☐ Premiums $_____
  - ☐ Copayments $_____
  - ☐ Deductibles $_____
  - ☐ Finalize your decision for Medicare Parts A, B, C, D and Medigap

NO LATER THAN 3 MONTHS AFTER TURNING 65

- ☐ Enroll in all desired Parts during the initial enrollment period **(and Medigap enrollment)**
- ☐ Review all plan documents to confirm you have received your desired plan benefits, with correct premiums, copayments, and deductibles
- ☐ Receive your Medicare card (it's paper, not plastic)
- ☐ Confirm with your agent to be certain everything is correct

To contact Medicare with questions, call 1-800-MEDICARE (1-800-633-4227) TTY users can call 1-877-486-2048. Live chat with Medicare at Medicare.gov/talk-to-someone. Write Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare Costs Sheet - 2024

MEDICARE PART A (HOSPITAL) [318]

Premium: $0 for most [$278-$506 if didn't pay Medicare taxes for 10+ years]
Deductible: $1,632 per benefit period [each hospitalization]
Hospital Coinsurance: $0/day [first 60 days] and $408/day [days 61-90]
$816/day [for 60 lifetime reserve days after day 90]
Skilled Nursing Coinsurance: $0/day [days 1 – 20] and $204/day [days 21-200]
All Costs after day 100

TOTAL (if not hospitalized) **Monthly Total** = **$0** For Most **$278-$506** If Pay for Part A

Yearly Total = **$0** For Most **$3,306-$6,072** If Pay for Part A

MEDICARE PART B (MEDICAL) [319]

Premium: $174.70* [2024 national base cost - *excludes any IRMAA payments*]
Deductible: $240
Coinsurance: 20 percent of the Medicare-approved cost of services
Monthly Total = **$174.70** **Yearly Total** = **$2096.40**

MEDICARE PART C (ADVANTAGE) [320]

Premium: Varies - $18.50 [2024 national average] *75% of enrollees don't pay a premium*
Deductible: Often $0 | Typically has a separate deductible for prescription drugs
Out of pocket limits: Capped at $8850 [in-network] and $13,300 [out-of-network]
Monthly Total = **$18.50** **Yearly Total** = **$222 + OUT-OF-POCKET COSTS**

MEDICARE PART D (PRESCRIPTIONS) [321]

Premium: $55.50* [2024 national average] | *Typically $0-195/mo before 2025 Inflation Reduction Act change*
Deductible: $545 maximum depending on plan
Coinsurance: may apply until out-of-pocket cap of $8,000 is reached
Monthly Total = **$55.50** **Yearly Total** = **$666 + OUT-OF-POCKET COSTS**

MEDICARE SUPPLEMENT (MEDIGAP) [322]

Premium: Average cost range of $50-$300 [depends on plan type]
Deductible: Usually covers all or a majority of Part A and B deductibles
Coinsurance: Out of pocket limit for Plan K and L are $7,060 and $3,530
Monthly and Yearly Total: **VARIES AND MAY HAVE ADDITIONAL OUT-OF-POCKET COSTS**

* *Additional charges (IRMAA) for higher income individuals may apply*

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